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# The JOURNAL

**of the**

# INDIANA STATE MEDICAL ASSOCIATION

**DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA**

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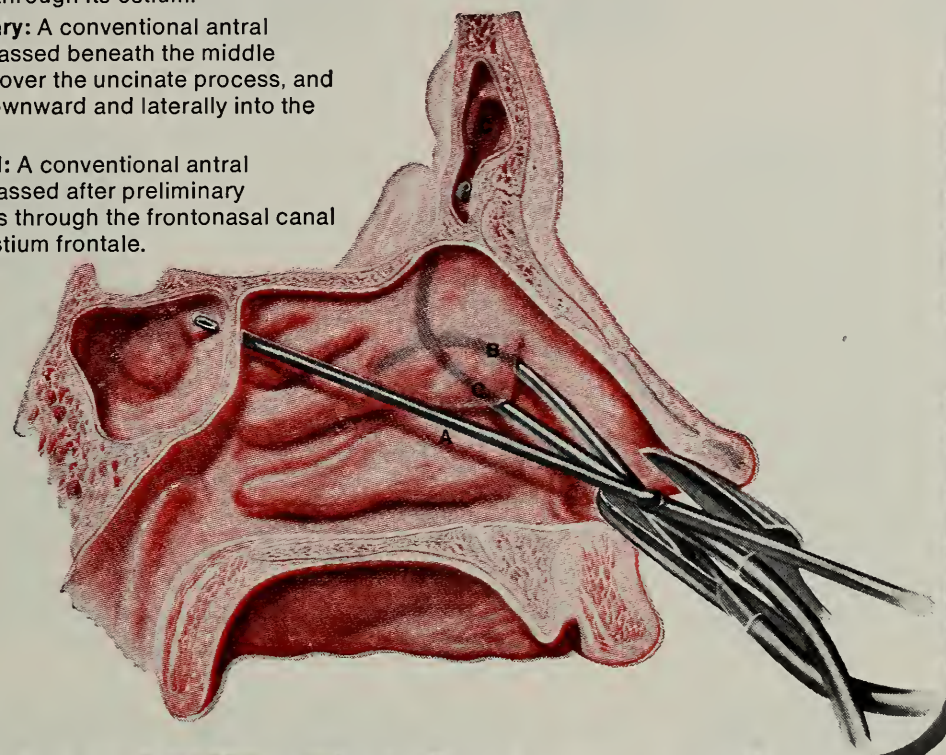
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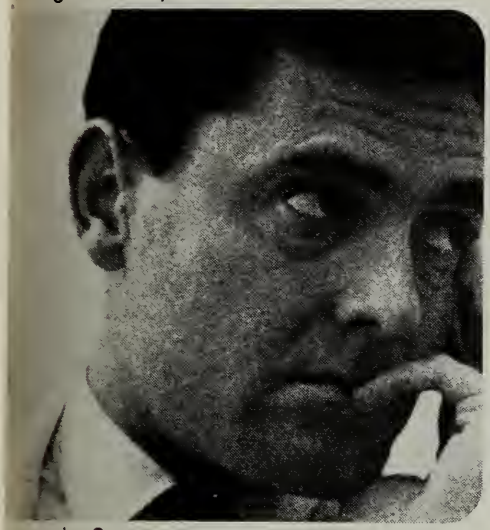
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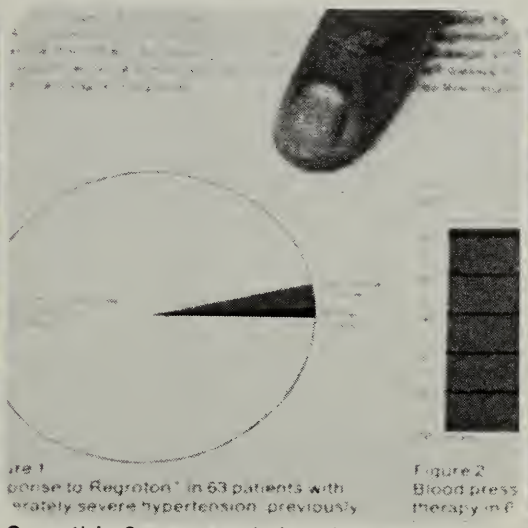
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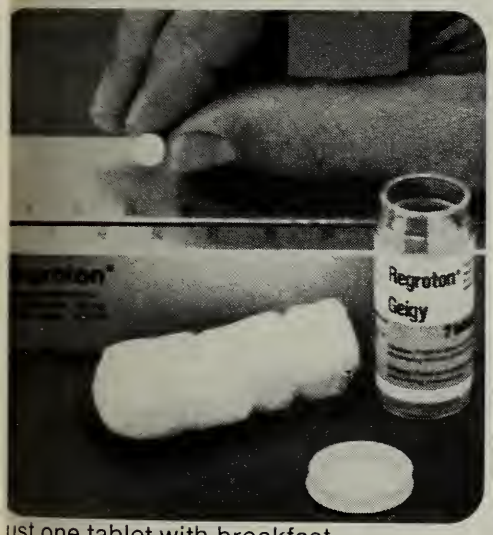
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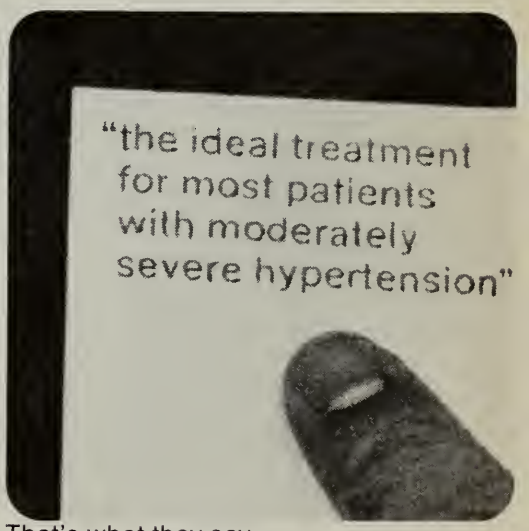
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# REASSURING SAFETY FACTORS

Effectiveness, dependability and reassuring Safety Factors make PABALATE-SF a logical choice for antiarthritic therapy in elderly patients—even when osteoporosis, hypertension, edema, peptic ulcer, cardiac damage, latent chronic infection and other common geriatric conditions are present. The potassium salts of PABALATE-SF cannot contribute to sodium retention...the enteric coating assures gastric tolerance...and clinical experience shows that this preparation does not precipitate the serious reactions often associated with corticosteroids or pyrazolone derivatives.

Side Effects: Occasionally, mild salicylism may occur, but it responds readily to adjustment of dosage. Precaution: In the presence of severe renal impairment, care should be taken to avoid accumulation of salicylate and PABA. Contraindicated: An hypersensitivity to any component.

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In each persian-rose enteric-coated tablet: potassium salicylate 0.3 Gm., potassium aminobenzoate 0.3 Gm., ascorbic acid 50.0 mg.

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# Of 507 patients with confirmed ear, nose and throat infections... 465 or 91.7% were treated successfully with Signemycin®

**Note:**
Adams,* whose 50 patients included 20 with ENT infections, stated that Signemycin "was particularly valuable in infections that did not respond to other antimicrobial agents, and in patients to whom penicillin could not be given." All his cases responded within five days; in most patients, all signs of infection disappeared in three days.

*Adams, J.: J. Tenn. Med. Ass. 50:446, Nov., 1957.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Otitis media | 90 | 86 |
| Pharyngitis and laryngitis | 162 | 148 |
| Sinusitis | 68 | 55 |
| Tonsillitis and peritonsillitis | 163 | 153 |
| Various | 24 | 23 |
| Totals | 507 | 465 (91.7%) |

## consistently effective...often when others fail

# Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

*Brief Summary and Bibliography follow.*

*Science for the world's well-being®* Pfizer *Since 1849*

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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D. C.—The Food and Drug Administration has started enforcing the prescription drug advertising provisions of the new law.

Sales of ethical drugs are now exceeding $2 billion a year in the United States. The Bureau of the Census reported ethical drug sales at $2.05 billion in 1963, the first year that they had gone over the $2 billion mark. The Pharmaceutical Manufacturers Association's figure was $2.39 billion.

The new law requires that prescription drug advertisements show:

—The "established name" of the drug, if one exists, in type at least half as large as that used for the brand name;

—The drug's quantitative formula, and

—A true and non-misleading brief summary of information about adverse side effects, contraindications and effectiveness of the drug for the guidance of physicians.

In enforcing these requirements, FDA said it would seek to determine whether a fair balance exists between the information on effectiveness and that on side effects and contraindications.

The FDA's Bureau of Medicine has started monitoring professional journal advertising for prescription drugs. It will forward violative advertisements with appropriate recommendations to the FDA Bureau of Regulatory Compliance.

Dr. Joseph F. Sadusk, Jr., Medical Director of FDA, said that it is the duty of physicians to keep fully informed of the composition, mode of action, efficacy and potential toxicity of drugs because as the potency of drugs increases, "so generally does their complexity and their potentiality for harm."

Violations of prescription drug advertising will be evaluated in two categories:

—Positive claims or omissions concerning the product which present potential danger to the patient in varying degrees. Examples include omission of some of the pertinent side effects, precautions or contraindications; improper statements about the effectiveness of, or indications for, the drug or antibiotic; omission of some of the information on various dosage forms, ingredients or directions for use where required.

—Claims which may or may not involve danger to patient health but which, in the selling message, can seriously mislead as to the proper place of the drug or antibiotic in the total spectrum of products available to meet a specific disease situation.

## AMA AND FDA ISSUE DRUG WARNINGS

The American Medical Association and the Food and Drug Administration

Continued



# Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

**Note:**
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Abscess, pulmonary | 17 | 16 |
| Bronchiectasis | 19 | 13 |
| Bronchitis | 286 | 267 |
| Bronchopneumonia | 192 | 179 |
| Empyema | 12 | 11 |
| Pneumonia, lobar | 150 | 146 |
| Pneumonia, other febrile | 160 | 150 |
| Various infected pneumopathies | 192 | 172 |
| Totals | ,028 | 954 (92.8%) |

## consistently effective...often when others fail

# Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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Continued

have warned that two fever and pain-relieving drugs are causing fatal agranulocytosis, a blood disorder, in some patients.

The drugs are aminopyrine and dipyrone, closely related compounds which have been dispensed widely by prescription for many years. Drastic label changes restricting the recommended uses for the drugs were announced by FDA. An editorial supporting the FDA action was carried in the AMA's journal, JAMA.

The FDA ruling was based on case reports collected by AMA and on recommendations of a special committee of medical experts in the fields of hematology, internal medicine, neurology, pediatrics and pharmacology.

## HOSPITAL ADMISSIONS SOAR

Nearly one million more people were admitted to hospitals in the U.S. in 1963 than in the previous year, according to the Health Insurance Institute.

The institute said that American Hospital Association statistics showed a record 25,267,000 Americans, or one of every seven, were hospitalized last year. This represents an increase of 960,000 over 1962. This means that each day more than 69,000 persons entered non-federal, short-term general and other special hospitals and that on an average day in 1963, there were 530,000 patients—2.8 per 1,000 population—under hospital confinement.

There were 698,000 beds available for patients in 1963, an average of 3.7 beds per 1,000 population.

The AHA, which includes terminal hospitalizations in its survey, found the average hospital stay for all ages to be 7.7 days. A study conducted by the U.S. National Health Survey, which included federal hospitals and was based on representative household interviews, put the average hospital stay at 9.4 days. It did not include terminal hospital stays.

The NHS report showed that persons with health insurance protection averaged shorter hospital stays than those with no insurance protection at all. This may indicate, the report suggested, that persons with health insurance protection will seek hospital care more often for diagnosis or for less serious illness than the uninsured.

The number of persons protected by hospital expense insurance provided by insurance companies, Blue Cross, BlueShield and other health care plans, rose to 145,329,000 by the end of 1963, the institute said.

Benefits paid by these organizations towards the costs of hospital care totaled $4,544,000,000, or an average of $12.5 million a day. Total health insurance benefits amounted to $7.8 billion.

## BILLION DOLLAR PROGRAM RECOMMENDED ON HEART DISEASE, CANCER AND STROKE

A Presidential Study Commission has recommended a $2.9 billion program on heart disease, cancer and stroke.

The research and treatment plan would be built around a network of regional centers designed to learn more about these diseases which cause 70% of American deaths.

The study group was set up by President Johnson in March and commissioned to draw up a blueprint for improving national facilities for fighting these diseases. At present the government is spending about $220 million in the research and treatment areas covered by the report.

The group urged establishment of a network of regional heart disease,

Continued on page 16



# Of 1,021 children with various confirmed infections... 950 or 93.0% were treated successfully with Signemycin®

**Note:**
The effectiveness of Signemycin was demonstrated by Chattas and his co-workers* who administered Signemycin to 30 children with serious staphylococcal infections resistant to commonly used antibiotics. Only one failed to respond. In each case the use of this drug was indicated by antibiogram. Those children treated with a nonselected antibiotic—for comparative purposes—took three times longer to recover.

Chattas, A. et al.: Antibiot. Med. 7:300, May, 1960.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Eye, ear, nose, throat infections | 368 | 343 |
| Respiratory infections | 369 | 346 |
| Gastrointestinal infections | 42 | 30 |
| Skin and soft-tissue infections | 38 | 37 |
| Deep-seated or generalized infections | 47 | 44 |
| Various conditions | 157 | 150 |
| Totals | 1,021 | 950 (93.0%) |

## consistently effective...often when others fail

# Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Signemycin is also available as half-strength Capsules, preconstituted raspberry-flavored Syrup and Pediatric Drops

*Brief Summary and Bibliography follow.*

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## SIGNEMYCIN®

**Side Effects:** Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

**Precautions:** Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

**Formulas:** Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

*More detailed professional information available on request.*

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# Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

**Note:**

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Ear, nose and throat infections | 507 | 465 |
| Respiratory infections | 1,028 | 954 |
| Gastrointestinal infections | 425 | 387 |
| Genitourinary infections | 748 | 684 |
| Skin and soft-tissue infections | 1,088 | 1,036 |
| Bone and joint infections | 71 | 64 |
| Deep-seated or generalized infections | 257 | 251 |
| Obstetrical & gynecological infections | 341 | 320 |
| Miscellaneous conditions | 592 | 570 |
| Totals | 5,057 | 4,731 (93.5%) |

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Continued

cancer and stroke centers "for clinical investigation, teaching and patient care."

These would be located in universities, hospitals, research institutes and other institutions.

Included would be 25 centers for heart disease, 20 for cancer and 15 for stroke to be established over a five-year period.

The program also would include a second national network of "diagnostic and treatment stations" located in communities throughout the nation. The purpose of this would be "to bring the highest medical skills in heart disease, cancer and stroke within reach of every citizen." This plan envisions 150 stations for heart disease, 200 for cancer and 100 for stroke over a five-year period.

The group also urged "a broad and flexible program of grant support" to stimulate more advanced research efforts in university medical schools, hospitals and other health care centers.

It suggested that the Public Health Service receive $25 million for such grants the first year which would be raised to $75 million the fifth year of operation.

The American Medical Association withheld comment on the report for the time being.

"If, however, legislation is introduced in the Congress calling for implementation of the program, the AMA will react at that time," a spokesman said. ◄

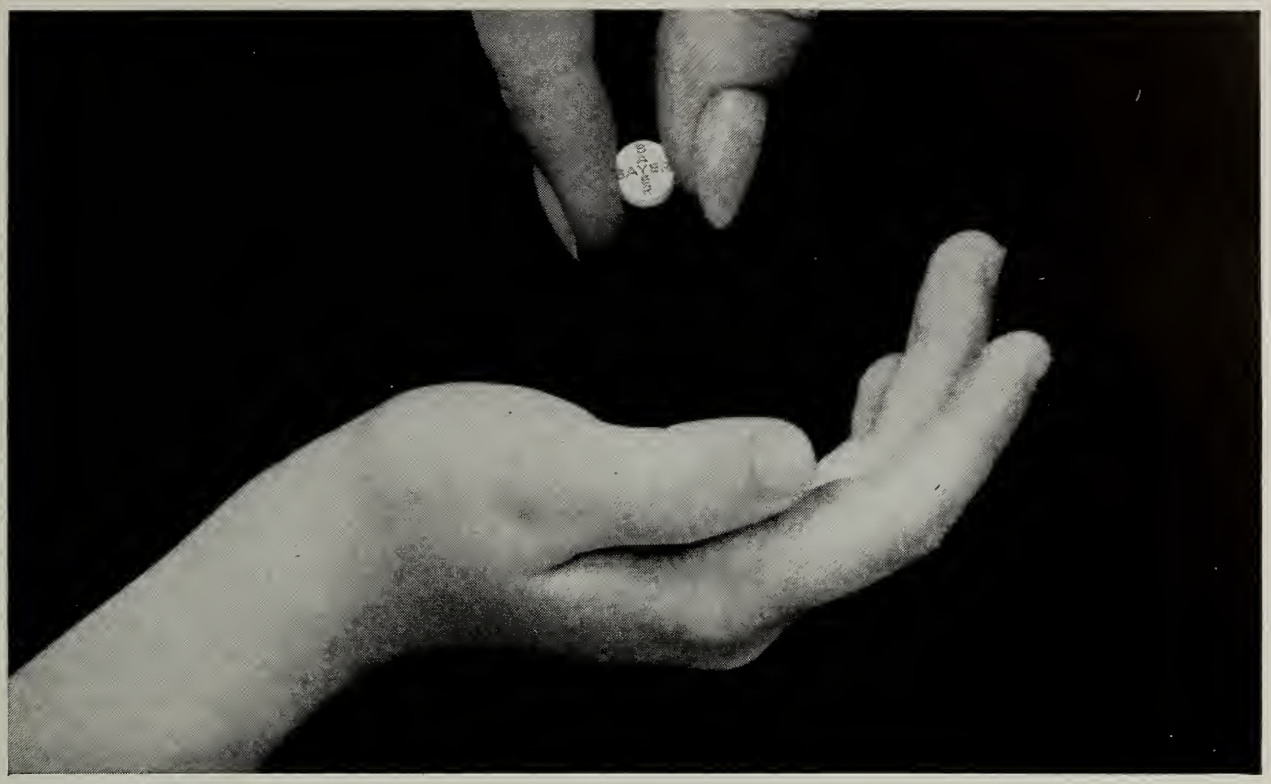
## From *The Journal* 50 Years Ago

. . . In the treatment of carcinoma of the stomach, like carcinoma elsewhere, the result will depend largely on the time of diagnosis. Early recognition of the disease offers the best chance of treatment, and surgery the only chance of cure.

In this connection it is of interest to read the report of Tunckenbein* of the treatment of inoperable cancer with autolysates. Remarkable improvement was noted in fifteen cases, following the intravenous injection of an autolysate derived from the patient's own tumor. This treatment is effective for both the primary and the metastatic tumors.

Prompt and marked relief from pain (the pain subsiding within a few hours following the injection in one case) is the chief effect of this treatment. The case in which the effect on the pain was so prompt had resisted the action of morphin (sic). All the cases in this series were benefited by this treatment in one or two weeks. . . . Garrette Van Sweringen, M.D. "Some Phases of the Year's Progress in the Fields of Medicine and Surgery", *JISMA*, January, 1915.

* *Am. J. Med. Scien.*, Nov., Vol. 128, p. 761, 1914.

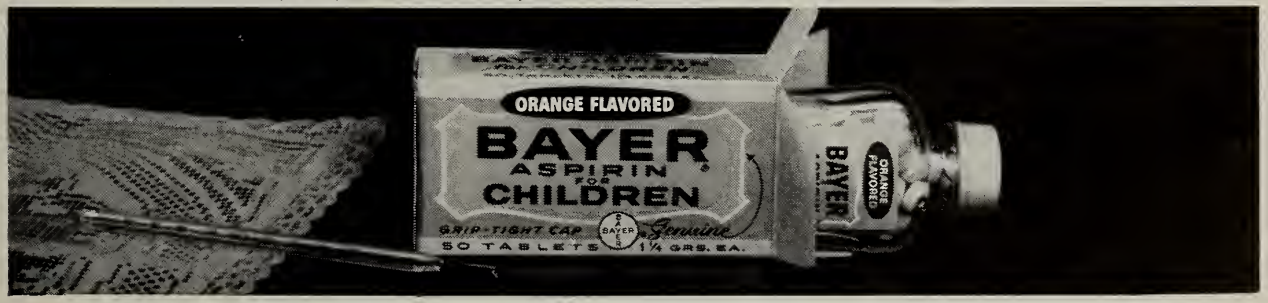


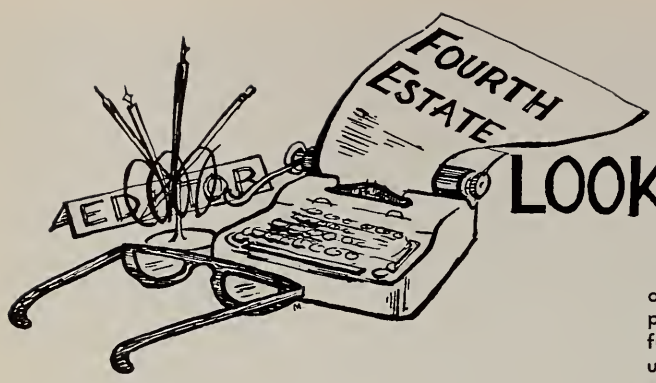
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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Medicare's Cost

With sizeable majorities in both houses of Congress, the Democratic administration should have little trouble achieving passage for favored legislation.

High on the list of bills scheduled for action is the Kennedy-Johnson plan to legislate a compulsory health program under the Social Security System, generally known as "medicare." Virtually the only thing now standing in the way of this legislation is Rep. Wilbur Mills, D-Ark., chairman of the House Ways and Means Committee.

Rep. Mills, co-author of the Kerr-Mills medical care act already on the books, does not think highly of the Social Security approach. With large "liberal" Democratic majorities, however, he may find it more politic to yield than to continue an unequal struggle. It therefore seems likely that "medicare," so-called, may soon be upon us.

This being so, the country should take thought and prepare itself for the new costs and new taxes to be imposed upon the citizenry to pay the bills. Despite the efforts of its proponents to suggest that the expense will be trifling, there is good reason to believe the new tax burdens will be grievous, particularly for those in low-income brackets.

This is so because the payroll tax out of which Social Security is financed is a so-called "regressive" tax, harder on the poor than on the well-to-do. It is a flat rate on the first $4,800 of income, the same for a man making $4,800 as it is for a millionaire. Under the existing "medicare" plan, the rate would be increased and the taxable base boosted to $5,200. The result would be to hike Social Security taxes to around 10% by the end of this decade.

Even this increase, however, would not be enough to pay the "medicare" bills — according to knowledgeable estimates. In the current issue of *Nation's Business,* Dr. Barkev Sanders, noted medical statistician, estimates the projected "medicare" program would actually cost three times current figuring and possibly four times as much. He adds that if the system were to come into operation in 1965, expenditures for it in 15 years' time would be about seven times current calculations. These estimates are based on cost trends for hospitalization, and on the British experience which found national health service expenses in 1963 running 700% over original estimates.

If the U.S. "medicare" program ran anywhere near this record, one of two things would have to happen: Either the Social Security payroll tax would have to be boosted astronomically, or else the system would rapidly go bankrupt.

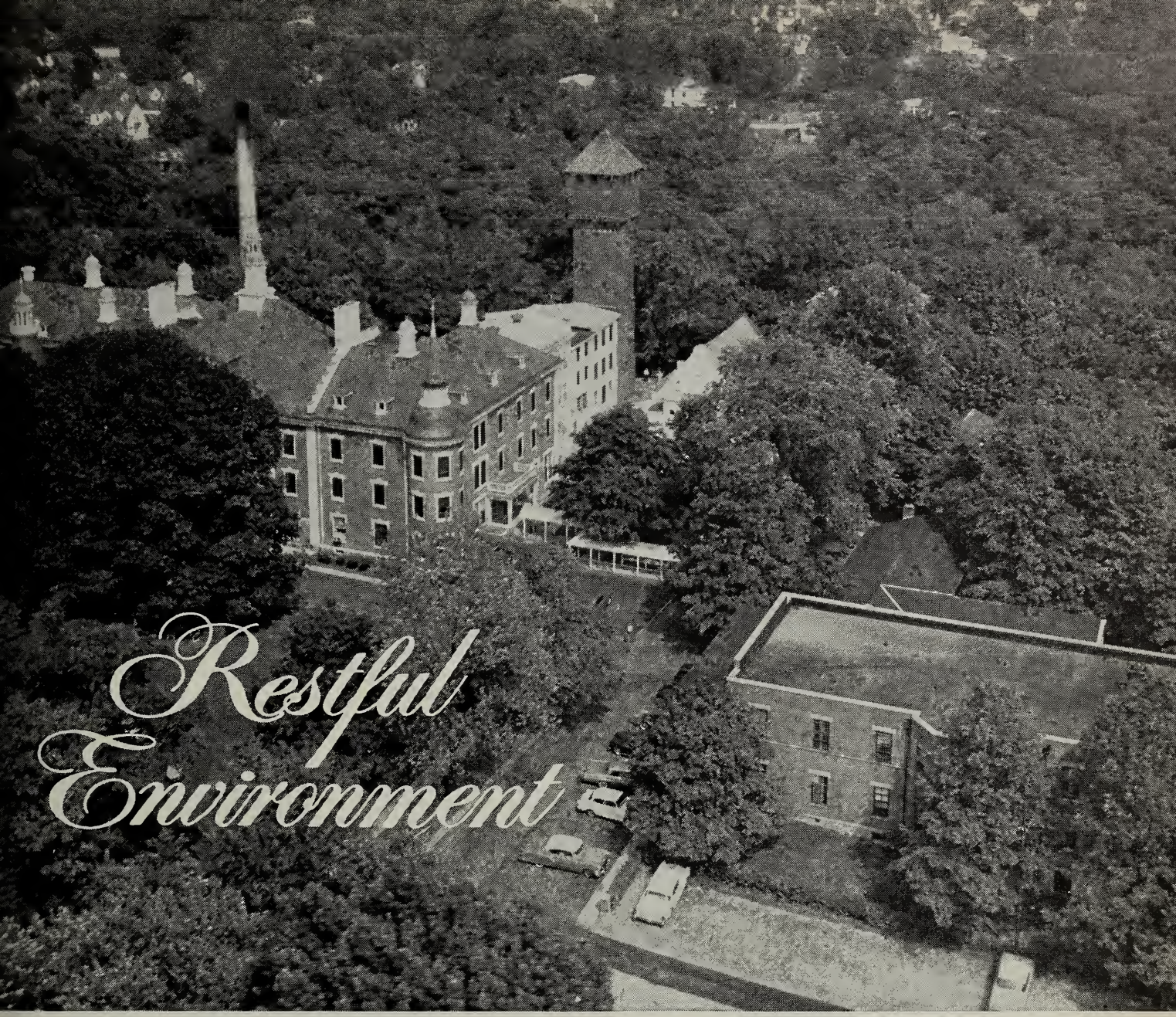
These are the prospects confronting taxpayers in the lower-income brackets if the "medicare" program goes through, as it appears will happen. In which case it should be apparent that the proponents of "medicare" are hardly the friends of the downtrodden they have been portraying themselves to be.—*Indianapolis News,* Nov. 23, 1964.

## Stay Out of That Jar!

When we think of peanut butter we think of small fry with gobs of the stuff spread over bread, and some spread over their faces.

When the Federal Food and Drug Ad-

Continued




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ministration thinks of peanut butter, it has the horrendous suspicion that the public is being short-changed on the quantity of peanuts in it.

A news dispatch from Washington says the FDA is preparing to issue an edict that all peanut butter must contain at least 90%, by weight, of peanuts. It seems that those creamy smooth products which have found their way into the market get that way by the addition of cottonseed or other oils. The more oil, apparently, the smoother and softer the product. The FDA thinks there should be a limit.

There must be a limit, all right. But shouldn't it be the taste and preference of the consuming public?

In our day we have known of small boys and girls—and older ones, too—who wouldn't hesitate to declare an opinion as to whether the new jar of peanut butter is better or worse than the last jar. We can't remember a single one asking what the percentage of peanuts was.

We suggest the FDA stick to requirements of honest labeling, and leave it to the eaters to decide what's a good peanut butter and what isn't.—*Indianapolis Star,* Dec. 19, 1964.

## Waste Unchecked

President Johnson's Commission on Heart Disease, Cancer and Stroke has recommended that the government spend $2.9 billion over the next five years in an all-out push to subdue these terrible killers. Significant scientific break-throughs in the last two or three years give rise to cautious hope that such a drive, augmenting work already being done by private, and charitable, research groups, could, indeed, help in reducing the annual toll in human life and suffering.

In 1963, alone, the commission reports, heart diseases, strokes and cancer accounted for 71% of all deaths in the United States. Heart diseases and strokes accounted for 994,747 deaths in that year while cancer claimed another 283,362.

In 1962, the last year for which such figures are available, these three killers cost Americans $22.4 billion in direct and indirect costs, or roughly four percent of our Gross National Product for that year. If only it were possible to translate the pain and suffering and the grief and hardship of the survivors into such neat statistics!

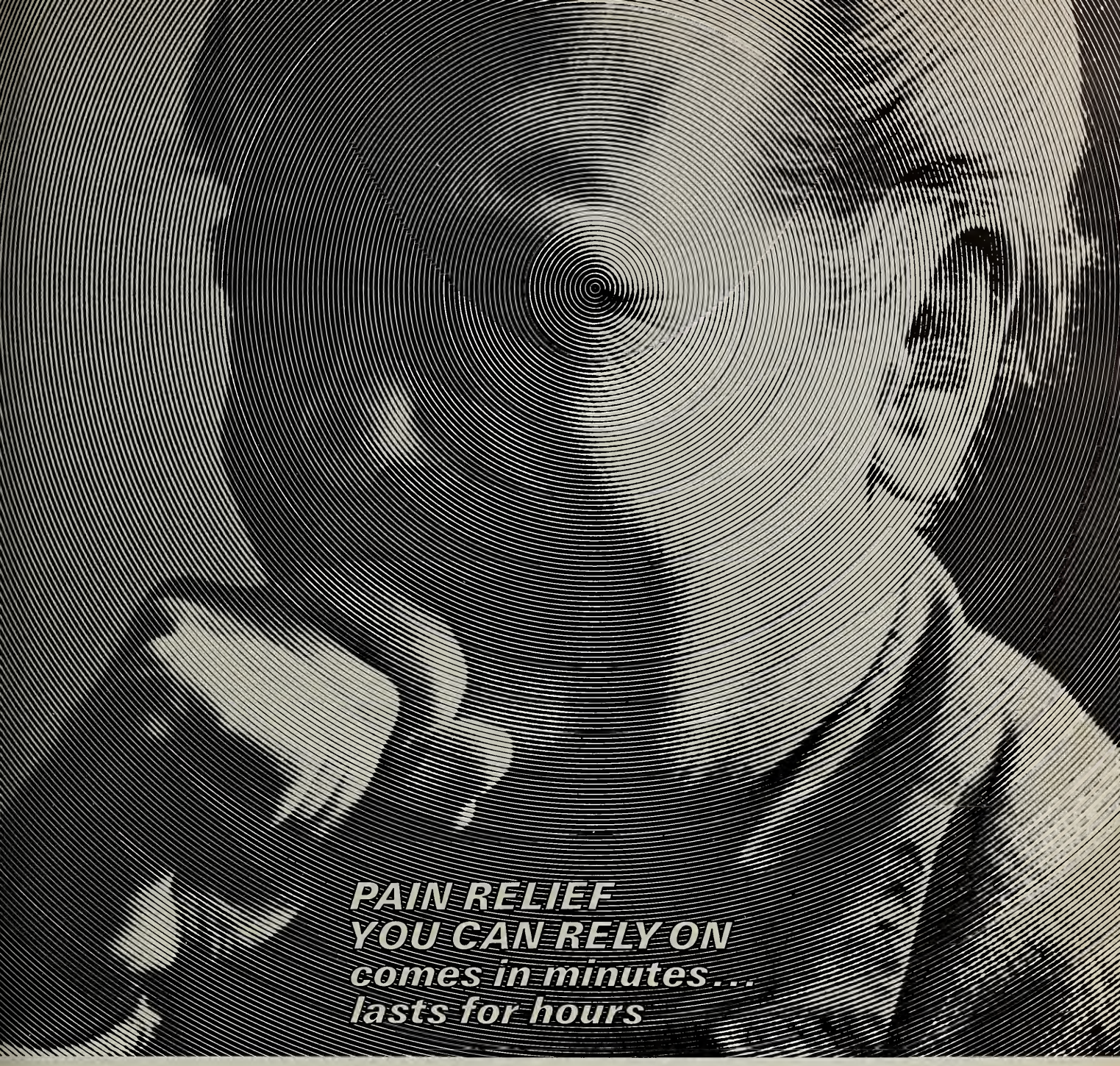
The virtual assurance that an intensive, joint-private-and-public research project such as envisioned by the commission could, indeed, reduce the toll significantly, leaves one with an almost infuriating sense of frustration and bitterness because—realistically—the odds are against the approval of such an expenditure.

Doubly frustrating because the expenditure, while large, amounts to only about $580 million a year over the proposed five-year program. "Only" we said?

"Only," indeed, when you consider that—in 1962—as thousands of American lives were being lost to heart disease, stroke and cancer, the United States government was pouring more than $762 million into India, Algeria and the United Arab Republic alone. In all, that year, almost $4 billion went into *all* foreign aid.

We have seen, in world reaction to our operations in the Congo recently, just how abysmally that money failed to buy us the friendship for which we have such an obsessive hunger. Had this waste been cut just 15% that year, and that money applied to the sort of intensive research proposed by the President's Commission on Heart Disease, Cancer and Stroke, tens of thousands of Americans who otherwise died might very well be alive today.

This sort of misdirection by a country that prides itself on its humanitarianism goes considerably beyond mere wastefulness. It is barbaric.—*Indianapolis Star,* Dec. 17, 1964. ◄




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## Letter

## to the editor

November 30, 1964

To the Editor:

The cover picture on the current (November 1964) issue of *The Journal* and the accompanying editorial by "J. F. S." on page 1235 are thought provoking.

Taken as stated, the first sentence of the editorial sounds like the "Voice from Mt. Olympus"—a sort of "I have spoken—so be it." I'm sure that under many battleground situations the statement is true, but I definitely wonder about the home front.

The question, "So why not hospital heliports" posed in paragraph three, suggests that such heliports would solve all the problems expressed in paragraph two.

Under the specific situation cited, at the 500 Race Track, where specific hazards are anticipated and a specific area designated for helicopter landings, transportation of accident victims has been facilitated by air. I wonder how such transportation could be effected from the scene of an accident at Washington and Meridian Streets or any other busy intersection of our city. Even in the residential areas, few back yards are uncluttered by telephone, power or clothes lines. So, it looks to me like helicopter ambulance service would have very little usefulness in an urban community. In the service of rural homes or country highways with adjacent open fields, this might be a real boon.

While on the subject though, several questions come up. Does anyone have the figures on the accident rate from helicopter flights on regular runs? on unscheduled flights? For that matter, what is the accident rate of ambulances driving "siren shrieking" through our streets? This last is prompted by a recurring question in my mind as to the number of lives that are actually saved by the few minutes of extra speed obtained by such "siren shrieking" and the usual disregard of ambulance drivers of all traffic regulations?

So before proposing a heliport at all hospitals, or even at Community Hospital, it seems to me that considerable study of the whole subject needs to be done. ◄

Sincerely,
John S. Pearson, M. D.
Medical Director,
American United
Life Insurance Company

### DO YOU HAVE A HEMOPHILIAC PATIENT?

**The Indiana State Chapter of the National Hemophilia Foundation is seeking information as to the number of hemophiliacs in Indiana. Medical practitioners throughout the state treating hemophiliac patients are urged to send the names, ages, addresses and details of the type of hemophilia of such patients to Mr. S. T. Friedman, Secretary of the Medical Advisory Council of the Indiana State Chapter of the National Hemophilia Foundation, 3946 Washington Blvd., Indianapolis 5.**

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 58 — January 1965 — Number 1

# A Case of Gas Gangrene Successfully Treated by Hyperbaric Oxygenation

*THOMAS A. BRADY, M.D.*
*GEORGE REISDORF, M.D.*
*Indianapolis* *

THE THEORY of treatment of gas gangrene with hyperbaric oxygenation (HBO) lies in the fact that the causative organisms, Clostridium perfringens (welchii), Cl. septicum, Cl. sordellii and Cl. novyi are obligate anaerobes, requiring an oxygen-starved environment in which to grow. There are many varieties of Clostridia, most of which are unimportant to this discussion in that they do not cause gas gangrene, are only contaminants in wounds or are non-pathogenic.

The alpha toxin of gas gangrene infection is a lecithinase. It causes hemolysis and is the chief lethal agent. The hemolysis leads to anemia, hemoglobinuria, oliguria, jaundice and often death. There is also a theta toxin, an upsilon toxin (a hyaluronidase, permitting dissemination) and other enzymes which either split proteins or sugars. It is in the last group that we find the agents responsible for the production of gas and crepitation.

In addition to muscle gangrene, anaerobic cellulitis develops in about five percent of traumatic wounds containing Clostridia, the incubation time being about three to four days. This infection does not involve muscle but may involve any other soft tissue. Gas gangrene developed in 1.5% of war wounds containing anaerobes. The incubation period was usually short, seven hours to three and one-half days in Cl. perfringens infections, or as long as six weeks in Cl. novyi infections. Death may occur within 24 hours after the onset of gas gangrene.

Usually there is profound intoxication with high fever, rapid pulse, prostration and apprehension. Locally there may be a "mousy" odor, pain in the wound, swelling, redness and crepitation. The extent of the bubbles of gas produced by the organisms may be accurately determined by x-ray. When infection becomes established, it travels in the inside of the muscles and, unless surgical extirpation is accomplished, together with the use of antibiotics, gas gangrene antitoxin and oxygen, the patient will almost certainly die.[4]

Infections are almost always mixed, but Cl. perfringens is found in 60 to 80% of cases of gas gangrene. When the causative organisms are Cl. novyi, Cl. septicum or Cl. sordellii, without Cl. perfringens, the lesion is characterized more by edema than gas. Gas gangrene must be suspected in wounds exposed to soil or fecal contamination, or when the wound has been exposed to prolonged water immersion. One of the authors treated five cases of gas gangrene complicating compound fractures incurred

* From the Department of Orthopedics, Methodist Hospital.

when a plane crash-landed in the water. It is interesting to note that gas gangrene may follow rupture of an abdominal viscus, a situation which does not, unfortunately, lend itself to the amputation treatment available for limb infection.

It was reported in 1958 that the U.S. Armed Forces had deleted gas gangrene antitoxin from the items available in its supply system.[9] The value of its use is a subject of controversy.

Recent studies have suggested that hyperbaric oxygen treatment might offer a safe and effective means of treating this alarming disease.[1-3,5,6,8,9-14]

### Case Report

A 20-year-old white male was admitted to Methodist Hospital on July 22, 1964. Just prior to admission, he had sustained a crushing injury to the lower aspects of both legs when he was pinned behind a bulldozer for five minutes. Roentgenograms of the lower extremities revealed no major fractures, but the patient's soft tissues, especially the calf of the left leg, were macerated. He was given 1 cc. tetanus toxoid and debridement of the wounds was done.

The muscles of the left leg had been lacerated, making accurate approximation of the tissues impossible. Primary closure was accomplished and multiple puncture incisions were made in the skin flap. A plaster cylinder was applied to the left leg and oral penicillin was given.

The parents of the patient were alerted to the possibility of fat embolism, gas gangrene or crush syndrome. He was followed closely with measurements of urine out-put and serial hematocrit determinations. The urine out-put was excellent and the hematocrit readings varied from 43% to 54%. The blood count showed a hemoglobin of 16.5 Gms. and a white cell count of 17,300 with 93% polymorphs. The urine analysis was normal.

The patient did well until late in the afternoon of July 23rd when his temperature rose to 105°. His pulse rate was 120. On July 24th, 36 hours postadmission, his temperature was 102° and the pulse rate was 100. He complained of pain in the calf of the left leg and the cast was removed. The skin margin at the wound site was found to be necrotic; foul drainage was oozing from the margins of the skin flap. Material from the wound was cultured for anaerobic organisms.

The patient was again taken to the operating room and much necrotic muscle was removed with some of it already liquified. Multiple skin incisions were made over the medial portion of the left leg extending into some pockets of gas. A loose dressing was applied to the left leg wound and 60,000 units of gas gangrene antitoxin were administered intravenously. Penicillin was given in large doses both intravenously and intramuscularly. An oxygen tent supplying 12 liters per minute was added to the regimen. Periodic intramuscular gas antitoxin injections followed the initial dose; the presumptive diagnosis at this time was gas gangrene.

On Saturday morning, July 25th, the patient was clinically improved. The temperature was 99° and the pulse rate was 90. The hemoglobin had dropped to 13.8 Gms. and the white cell count was now 12,000, with 88% polymorphs. Late that evening, inspection of the left lower extremity revealed crepitation in the medial aspect of the lower thigh. The patient was returned to surgery immediately. Incision into areas of crepitation in the lower thigh revealed necrotic subcutaneous tissue which was removed. A catheter was placed in the wound of the left calf for delivery of oxygen at two liters per minute. A preliminary report on the culture showed both gram negative and gram positive rods as well as a few spores.

Early on July 26th, the patient appeared to be responding to treatment. Shortly after 1:00 p.m., however, his condition suddenly worsened. He developed a ballooning of the scrotum with gas, abdominal discomfort with palpable areas of crepitation and emphysema of the subcutaneous tissue of the neck. The temperature was 104° and pulse rate 130. The patient complained of some dyspnea. Amputation was considered.

A telephone call was placed to Dr. Jack Van Elk, Director of the Hyperbaric Research Center, Lutheran General Hospital, Park Ridge, Illinois, concerning the pos-

sibility of subjecting the patient to hyperbaric oxygen therapy. He recommended flying the patient to him at once. The patient was admitted to Lutheran General Hospital at 6:00 p.m. the same day, and that evening he was placed in the chamber and subjected to oxygen at three atmospheres of pressure. Within 18 hours, the patient was considerably improved. The total treatment lasted six days and the patient was subjected to ten sessions in the chamber, each lasting two hours. He was released from the hospital on August 9, 1964, and was readmitted to Methodist Hospital in Indianapolis for a skin graft to the left leg (Figure I). A final culture report showed a mixed infection including Clostridium perfringens.

### Discussion

The management of severe infection caused by anaerobic organisms consists of excising dead tissue. Various workers advocate local application of hydrogen peroxide, general oxygen therapy through a mask and local oxygenation by encasing the limb in an airtight bag containing $0_2$. Boerema and Brummelkamp have carried tissue oxygenation a step further by allowing the patient to breathe pure oxygen in a pressure chamber.

In the case reported here, hyperbaric oxygenation was not only a life-saving procedure, but it spared the extremity, allowed conservative treatment in the presence of manifest Clostridial necrosis and preserved viable tissue to the greatest extent.

### Clinical Application

Within the last decade, the possible benefits of a form of therapy whereby oxygen is administered under increased pressure have been investigated. Most of the experimentation was done at a pressure only a fraction above one atmosphere, however, and no notable successes were obtained. Boerema, at the Royal Dutch Navy School, began his studies in 1956 and performed the first operative surgery in a hyperbaric chamber, combining it with hypothermia. In 1960, Smith et al., published a study of 40 cases of carbon monoxide poisoning treated with HBO.



**FIGURE 1**

**PATIENT'S leg showing skin graft covering surgical defect. This photograph was taken at the time of readmittance to Methodist Hospital after successful HBO treatment at Lutheran General Hospital.**

Since then, Illingsworth has been able to state that any patient with carbon monoxide poisoning who is still alive when he reaches the hospital can be saved. In another study, 40 cases of gas gangrene were treated with HBO and all but two survived. The mortality of hyaline membrane disease of the newborn has been cut from 66% to 33% by this therapy.[13] A glowing report of the treatment of nine cases of tetanus with HBO recently originated in Chicago. The progression of the disease was arrested, symptoms abated and the need for tetanus antitoxin and tracheostomy was avoided. Most importantly, seizure occurrence was diminished and finally abolished.[7]

Hitchcock has pointed out that this method has a very large number of potential applications, including cardiac surgery, vascular surgery, acute coronary attacks, peripheral vascular insufficiency and some pulmonary conditions, as well as the uses mentioned above. In addition to this, much information has been gained by Naval investigators in problems of decompression. Work has also been done in aviation medi-

cine in studying the physiological changes in pressure chambers.[5]

The normal oxygen tension in the arterial blood is around 100 mm. of Hg. If a patient wears a tight fitting mask at one atmosphere pressure, breathing 100% oxygen, the oxygen tension may rise to from 500 mm. to 600 mm. Hg. However, if 100% oxygen is given in a chamber at three atmospheres pressure, a level of from 1,500 mm. Hg. to 2,000 mm. Hg. oxygen tension may be attained.

### Potential Problems

Several factors may make the administration of oxygen by this method difficult or ineffective — a defect in the alveolar membrane, anemias, compensated circulation with vasospasm, low blood pressure, a decreased rate of flow, lack of contact of specific parts with the circulation, shunts or defects in the heart.[5]

Investigators have been aware of other difficulties inherent in HBO therapy. These include the decompression problems associated with the transfer from high chamber pressure to normal outside pressure and toxicity from oxygen itself. With cautious decompression as practiced at the Lutheran General Hospital, there should be no problem with the former difficulty, and, according to the investigators at that institution, there have been none.[3] Medical and nursing personnel also have to enter the chambers, so attendants should be selected with care as to the state of health of their sinuses, and middle ears, or the presence of pulmonary blebs which may rupture during decompression. It is worth noting that Smith of Scotland, with several thousand hours experience with HBO, has experienced none of the potential complications just referred to.

Oxygen toxicity is a factor well recognized and documented by investigators. It is known to manifest itself in at least two ways. One is by effecting a change in the membranes of the alveoli and the rest of the bronchial tree. A second manifestation of oxygen toxicity is convulsive seizures.

Clearly high pressure oxygen therapy is not without its difficulties and dangers. The hazard of oxygen toxicity as estimated by experimental and clinical knowledge, should not deter the use of the agent if it is as valuable as it seems.

The question now arises regarding the advisability of building HBO centers, are we sure that the method is of sufficient value to warrant the cost and are there any considerations that would make us think twice about constructing one of them.

The Research Council of the National Academy of Sciences has evaluated this question in the light of three criteria. If the method is uniquely beneficial over other methods, if it is practical for use in at least a few important medical conditions and if it is applicable to a reasonable number of patients, only then will the method justify the effort to make it generally available. Otherwise, it should be confined to a few large centers. Most scientific researchers recognize that this tool has not been adequately studied in all its potential uses and dangers. It can be stated that the most prominent successes have been in treating carbon monoxide poisoning, gas gangrene and tetanus.

### Summary


1. A case of overwhelming gas gangrene infection was successfully treated with hyperbaric oxygen therapy. Not only was the patient's life saved but the involved limb was salvaged, too.
2. Clinical usage of HBO is discussed with reports of dramatic recovery in cases of gas gangrene, carbon monoxide poisoning and tetanus.
3. Patients in central Indiana should have access to this therapeutic facility.


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## Varied Opinions of Drug Usefulness

The (pharmaceutical) industry believes that since the practice of medicine is not yet an exact science and since the body cell is often unpredictable from body to body, even hour to hour, there should be proper recognition of the fact that differences of opinion in medicine over usefulness of product and technic will continue long after all of us here today are gone.

The bedside approach to the sick person is still more dependable than slide rule application from a protected arm chair. Differences of opinion simply must be recognized, appreciated and accepted when such differences emanate from well informed and medically accepted sources.

Otherwise, decision making for the majority of the sick may well cause death for the minority of the ill as legislators, regulatory officials, hospital administrators and welfare agencies attempt to apply formulas rather than reason to matters involving the use of new medicines.—Austin Smith, M.D., in *Experimental Medicine and Surgery* 22:2-3, (June/Sept.), 1964.

# Constancy and Change in Neurosurgery*

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THE MOST CONSTANT characteristic of neurosurgery is the fact that it is constantly changing. A man who practiced neurosurgery at the time of Harvey Cushing's death (1939) would hardly recognize it as being the same specialty today. Interestingly enough, however, Cushing himself would probably feel very much at home in neurosurgery as it is practiced today. More than being a great technical surgeon, Cushing was first and foremost a physiologist in the broadest sense.

### Hypophysectomy

The neurosurgeon today must be an adept physiologist also if he is to practice his art. A good example is the development of hypophysectomy for the treatment of metastatic breast cancer by Bronson Ray[24] of New York, formerly of Fort Wayne. Hypophysectomy has been used for breast cancer because of the endocrinological effect of the activity of the pituitary on many of these cancers. The average neurosurgeon in private practice today, of necessity, has to be his own endocrinologist when it comes to treating the postoperative state of the hypophysectomized patient.

In Cushing's early days, he used to remove the pituitary for tumors and for acromegaly, through a trans-sphenoidal approach.[9] This approach went into eclipse for a while because of the incidence of meningitis which accompanied it. But as things *do* go full cycle, the trans-sphenoidal route is again being used.[13] Now, though, rather than removing the pituitary with sharp instruments, this author and others,[7] destroy it with a freezing probe (Figures 1 and 2). The so-called trans-sphenoidal cryogenic-destruction of the pituitary is being used not only for cancer of the breast and for acromegaly, but also for severe, brittle diabetes, especially in those persons with diabetic retinopathy or other major complications.[17]

The problems of managing a hypophysectomized individual with a malfunctioning pancreas who may have altered adrenal function and occasionally diabetes insipidus, is no small problem; but it is one which most neurosurgeons have to manage themselves until the patient becomes stabilized.

### Brain Injury

By the same token, the problems of management of the brain-injured patient or the patient who is comatose for some other reason is largely a matter of the management of his fluid, electrolyte and nutritional balance,[6] as well as the management of his cerebral edema.[11] The problems of cerebral oxygenation can be subtle but fortunately can usually be handled by adherence to the old dictum that "when you think you might need a tracheotomy later on; do it now."[16]

Added to these problems of the brain-injured patient are associated and coincident problems such as cryptogenic blood loss in bruised tissues, especially around fractured femurs and vertebrae; the problems of myocardial injury; injury to the chest wall and the lung parenchyma; renal injury, and so on, therefore it is evident that one's knowledge of physiology can be strained to the utmost.

The major challenge of the neurosurgeon attending a brain-injured individual is more frequently the problem of preventing biochemical death than of removing subdural and epidural hematomas. Anyone able to put in the time needed to work with such patients can do as good a job as any neurosurgeon. The only advantage the neurosurgeon has is that he has become adept at managing the injured person's altered physiology. He eventually reaches the point where he does it almost automatically. The care of the comatose person is truly the care

* This paper was read before the Grant County Medical Society, October 23, 1963.

of the whole man.

Besides the person with a severe head injury, the neurosurgeon frequently sees the person who has developed symptoms such as chronic severe headache, dizziness and the like, following recovery from a head injury. Study of such persons has branched out into two different directions. In one, the psychosomatic mechanisms for the development of these symptoms has been elucidated to a considerable degree and with this elucidation has come considerable knowledge concerning the management of the neurotic patient.[2,15]

Secondly, many of these patients have sustained neck injuries as the result of the blow to their head and they may have symptoms directly due to the neck injury.

### Cervical and Lumbar Disc Injury

The realization of the importance of neck injuries sustained simultaneously with head injuries has in turn led to an increased understanding of the symptomatology associated with ruptured cervical discs, cervical spondylosis and even with cervical radiculopathies associated with cervical arthritis. Ralph Cloward, a neurosurgeon in Honolulu, has developed one of the new operations of recent years, the so-called anterior cervical body fusion.[5] With the development of the anterior cervical body fusion (Figure 3) has come an increased appreciation of such things as the patterns of referred pain upwards to the head and downward into the arm, the anterior chest wall and into the back.



**FIGURE 1**
**X-RAY DEMONSTRATING cryogenic probe positioned in sella turcica for hypophysectomy. The probe was withdrawn about 3 mm. prior to beginning actual freezing.**

It is generally realized that neurosurgeons consider the problem of the ruptured disc, both in the neck and below, to be a neurosurgical problem[4,25] despite the fact that their orthopedic colleagues undoubtedly remove many more of them.

This opinion is based on the fact that those who handle brain tissue have rather a different touch with, and understanding

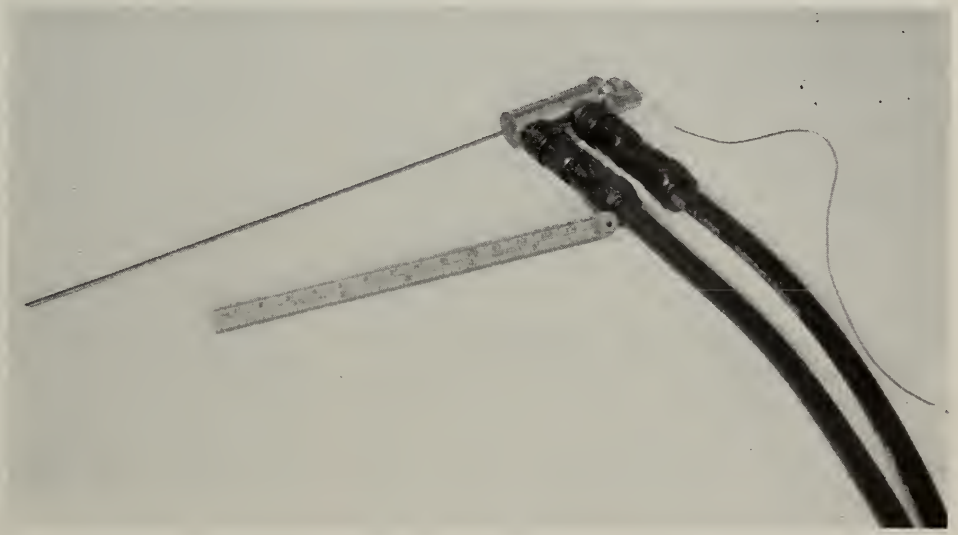


**FIGURE 2**
**PHOTOGRAPH of Freon-22 cryogenic probe. The wire leading off to the right is the thermocouple connection; next to it are the intake and outlet hose connections.**

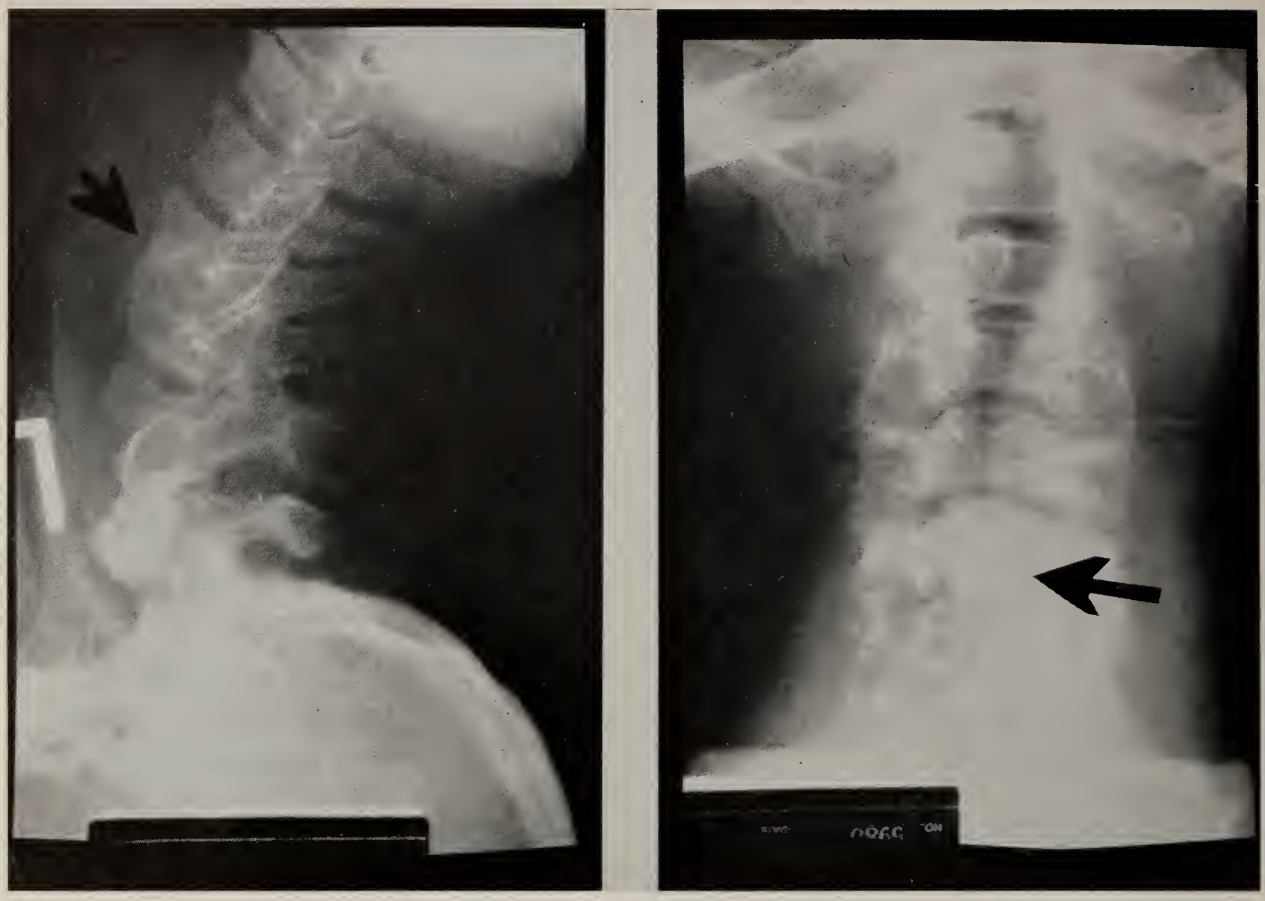


FIGURE 3

X-RAYS of patient with C3-4 anterior cervical body fusion. The arrow points to the plug of iliac bone used for the fusion.

of, the tissues within the bony confines of the central nervous system than those whose more usual work utilizes hammers, saws and chisels.

## Pain

One of the most invariable things about neurosurgery is its concern with the problems of pain and the management of painful states.[23] The word "pain" is used with hesitancy because of the realization that *pain* is a matter of personal interpretation. Statements such as "he has *real* pain" or "there *must* be a cause for the pain because it is so severe" imply that the speaker has closed his mind to the causes of pain.

Some of the most disturbing problems which face the neurosurgeon are persons who complain of intractable post-herpetic pain[29] or pain following an adequate cordotomy for the agony of pelvic carcinoma or intractable face pain after a successful rhizotomy for tic douloureux. Though psychiatry is not in the province of the neurosurgeon, he must have a total understanding of the mechanisms of pain if he is to avoid such horrible sequences as treating an amputee with a painful phantom limb, first by excision of a neuroma, then by a peripheral neurectomy, then by a rhizotomy, a cordotomy, a mesencephalic tractotomy, a cortical resection and finally by a prefrontal lobotomy.

It is essential to recognize that the mechanism of symptoms such as intractable pain following a tic douloureux operation is due to the fact that the altered sensation disturbs the patient's appreciation of the sense of his body to a degree which is intolerable and insufferable. In the English language we have but very few ways to describe suffering except to say that it is painful.

## Brain Tumors

The most continual concern of the neurosurgeon is the problem of brain tumors. Neurosurgery was developed primarily to cope with brain tumors and their treatment continues to be the bedrock of the neurosurgeon's practice. The technic of the man-



**FIGURE 4**

**LATERAL carotid arteriogram demonstrating the reversed bowing of the anterior cerebral artery due to its displacement by a meningioma of the tuberculum sella, proven at operation.**

agement of brain tumors is, however, in a constant state of flux and development. The technic of cerebral arteriography has been developed into a fine art[1,10] (Figures 4 and 5), and has been further refined to include the great vessels in the neck for the diagnosis and treatment of extra-cerebral vascular disease of the brain[22] (Figure 6). Radioisotope scanning[3] for brain tumor diagnosis (Figure 7) has been developing in the past few years, although, like electroencephalography, it suffers from certain artefacts and from the fact that it is sometimes incapable of distinguishing between a brain tumor and an infarct.

Radioisotopes are tremendously useful in the treatment of brain tumors. If a tumor is located beneath the surface of the brain and if the patient has been given radioactive phosphorus prior to surgery, locating the tumor with a probe-shaped Geiger counter is generally quite simple, obviating the necessity of exploratory incisions through the cortex, as is otherwise sometimes necessary.

The development of scientific anesthesiology has been the greatest single boon to the surgical treatment of brain tumors and from it have developed such procedures as hypothermia, new hypotensive technics and the use of hypertonic agents such as urea. Among the actual surgical tools, the cryogenic probe is being used in some quarters for the purpose of actually freezing the brain tumor so that it can be shelled out easier and with less blood loss than is possible using more conventional technics.[7]

The development of increasingly improving technics of postoperative radiation therapy is having a definite effect on survival, especially for tumors such as ependymomas and medulloblastomas.[8,28] Some of the "wild men" who were developing these technics 25 years ago can now point with pride to children who had unquestionably malignant brain tumors, who survived and who are now adults raising their own families.

The surgery of brain tumors is *not* hopeless. Unquestionably, the mortality is high. There are patients whose cerebral physiology has been so compromised by the time



FIGURE 5
ANTERO-POSTERIOR right carotid arteriogram of a glioma of the right thalamus. The arrow points to the fine tumor vessels. Proven at autopsy.

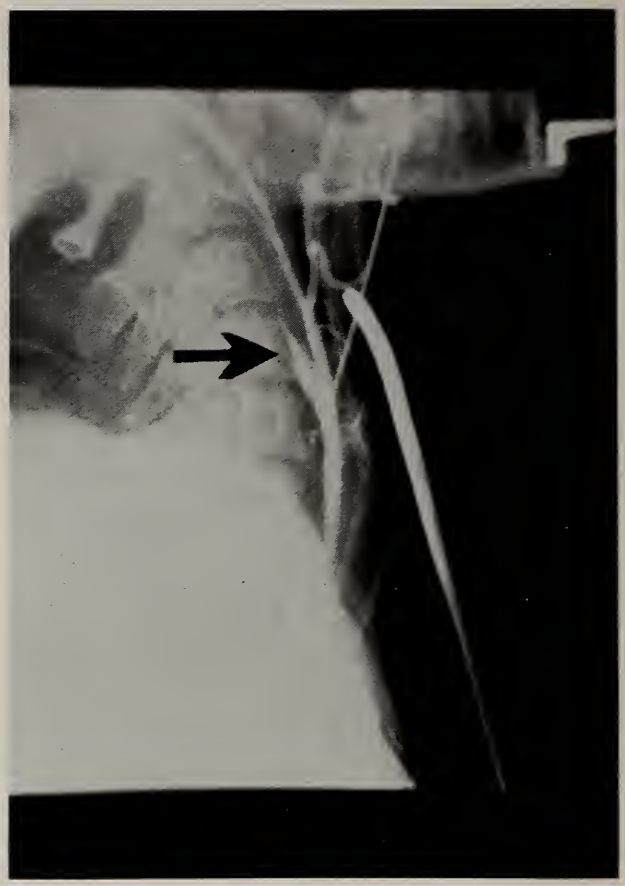


FIGURE 6
LATERAL arteriogram of the extracranial portion of the carotid artery demonstrating total thrombotic occlusion of the internal carotid artery in the neck of a woman whose complaint was of transient (several hours) hemiparesis. Proven at operation.

they get to the neurosurgeon that they simply cannot be salvaged. There are also tumors of such high malignancy and radioresistance that the patient cannot be saved.

But this is no different than it is for the surgery of malignancies anywhere in the body. The problem in the surgery of malignant brain tumors is, of course, that whereas one can remove an entire kidney, lung, stomach, bladder or breast without appreciably disturbing the person's physiology, one cannot remove the brain-stem or an entire cerebral hemisphere without making a person worse off than he was before he was operated upon. Such a procedure will not cure a malignant brain tumor anyhow.

Not all brain tumors are malignant, of course. The meningiomas and the acoustic neuromas are all benign tumors and if they can be operated upon before they have destroyed an excessive amount of cerebral tissue, the person can be cured and returned to a normal existence. The same is largely true with pituitary tumors[12] and with the understanding that massive preoperative and postoperative steroid therapy is necessary, the same is also true of the craniopharyngiomas.[30] Cerebellar tumors of children are benign in at least 50% of cases. Moreover, as mentioned above, some of the ependymomas and some of the medulloblastomas can be cured by radiation, after the brain has been adequately decompressed by surgery.

## Stereotaxic Surgery

There are at least two major new developments in neurosurgery. One of these is the development of the widely publicized stereotaxic procedure for the treatment of Parkinsonism[8,18] and related hyperkinetic disorders.[14,26] The overall accuracy and safety of these procedures is directly related to the accuracy of the stereotaxic system which is used. Unfortunately, some of the "stereotaxic" methods and instruments in current

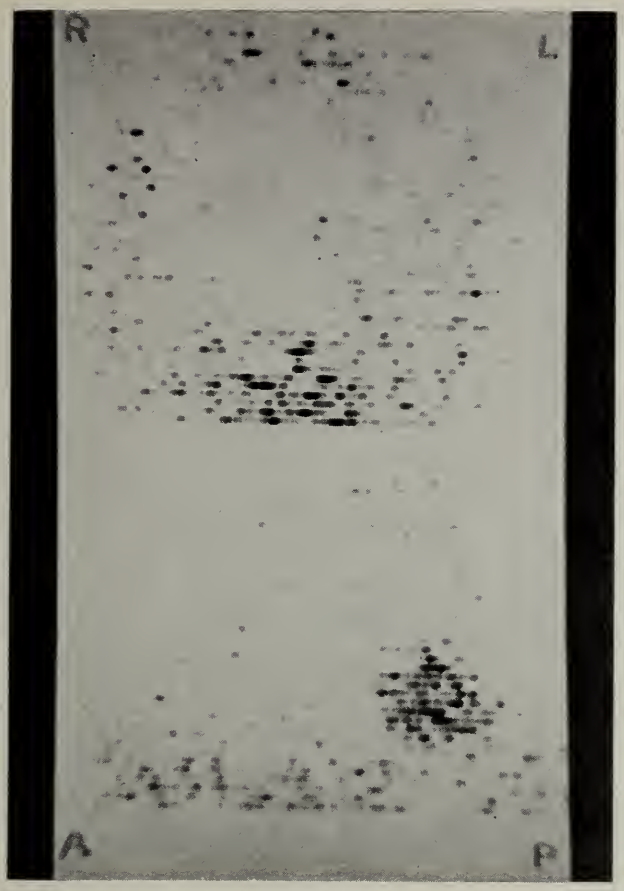



FIGURE 7
RADIOACTIVE mercury brain-scan. The concentration of "dots" is indicative of a glioma of the left occipital lobe, an area extremely difficult to demonstrate by conventional radiographic diagnostic methods. Proven at operation.

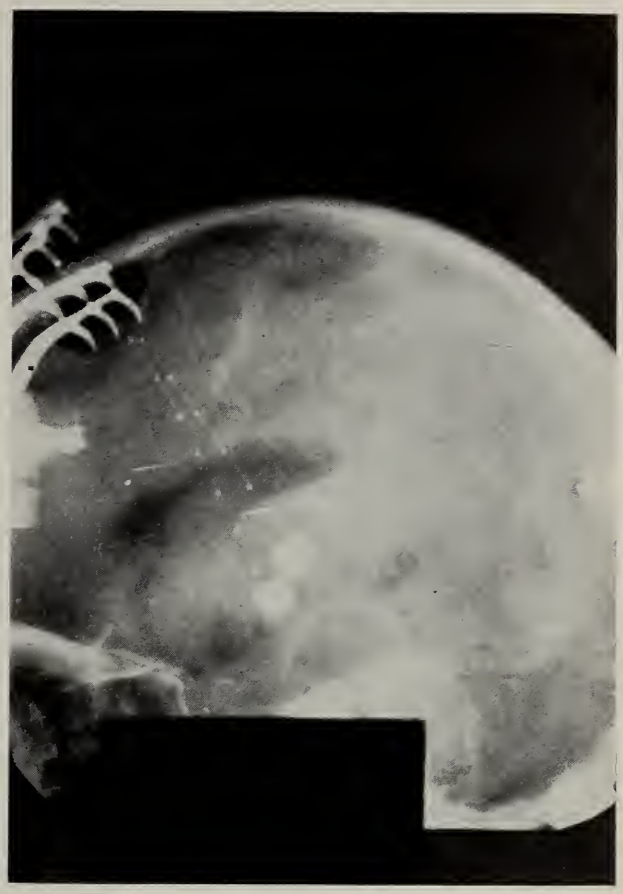


FIGURE 8
X-RAY demonstrating Cooper balloon cannulae stereotaxically positioned for chemothalamotomy for postencephalitic Parkinsonism. Patient remains cured over five years' postoperatively.

use are little more than hit or miss devices with which to introduce an instrument into the brain with less wobble than can be done free-hand. The development of *true* human stereotaxic surgery has been a slow and tedious process.[21] Nonetheless, the stereotaxic procedures for the alleviation of Parkinsonism are effective in a significant number of patients (Figure 8). Until the pathophysiology of Parkinsonism is better understood, however, it is a procedure which should be reserved only for those patients who cannot be adequately controlled medically, and for those individuals who are not seriously deteriorated intellectually.

## Epilepsy

The other relatively new procedure in neurosurgery is the surgery of epilepsy. At present, surgery for persons with convulsive disorders must be limited to individuals with uncontrollable seizures; whose seizures have a discrete electrical origin by EEG and whose seizures originate in a relatively non-critical part of the brain so that that portion can be excised. If these criteria are followed, well over half the persons with intractable focal epilepsy can be totally relieved of their seizures.

The surgery of epilepsy is not exactly new. Dr. Penfield of Montreal has been working on it since the 1930's. What *is* new are the methods of diagnosis and selection of patients.[20] Those of us who are seriously concerned with this problem are now introducing stereotaxically directed electrodes into the brain,[21,27] and leaving them there, sometimes for months, for the purpose of obtaining recordings directly from the brain, rather than having to rely on grossly inadequate scalp recordings (Figure 9).

I routinely use 80 to 144 intracranial electrode contacts for the preoperative investigation. Although this sounds like a tremendous number of wires to have in the head, the electrodes used in the present study are only .002" in diameter; slightly smaller than

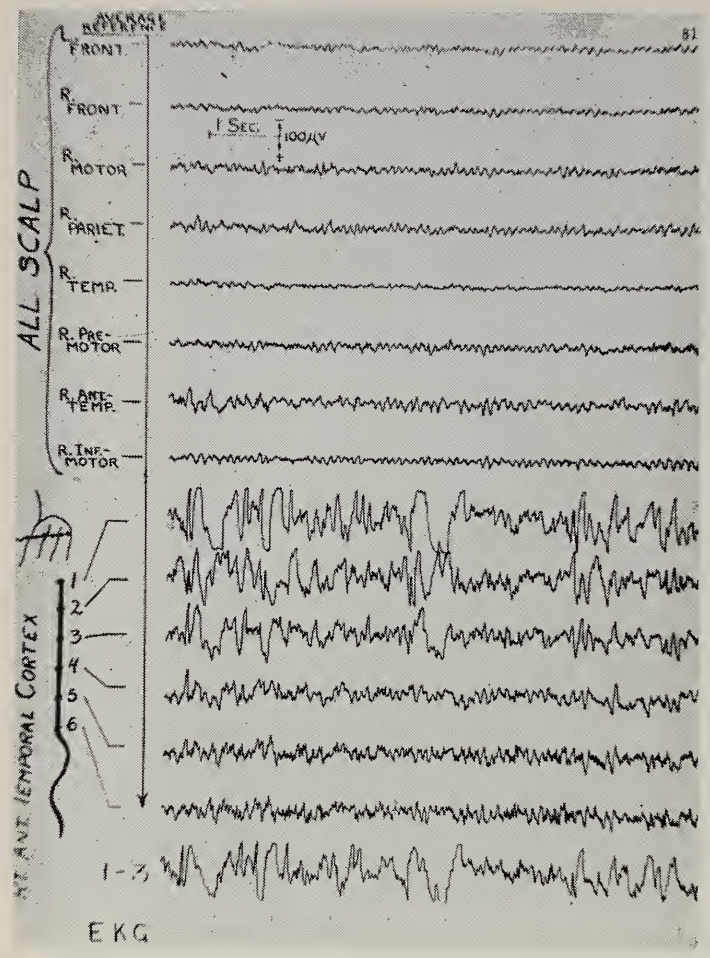



**FIGURE 9**

**DIFFERENCE** between electroencephalogram recorded simultaneously from scalp and from cortex. Channels 1 through 8 are recorded from various areas on scalp; channel 8 from right anterior temporal area. Channels 9 through 15 are recorded from the cortex of the tip of the right temporal lobe; channel 9 is most anterior and inferior; channel 14 is above the sylvian fissure. Note the great difference in the appearance of the abnormality recorded from the cortex in channels 9, 10, and 11, compared to the minimal changes noted on scalp (channel 8). Channel 15 is bipolar from contacts 1 and 3 on cortex. Channel 16 is EKG monitor.

the average human hair[19] (Figure 10). The advantage of this technic is that not only can the electrical focus be adequately located preoperatively but we can also tell when the patient has more than one focus; we can tell where the foci are and we can also tell if the problem is such that the patient can or cannot be benefited by a surgical resection.[20]

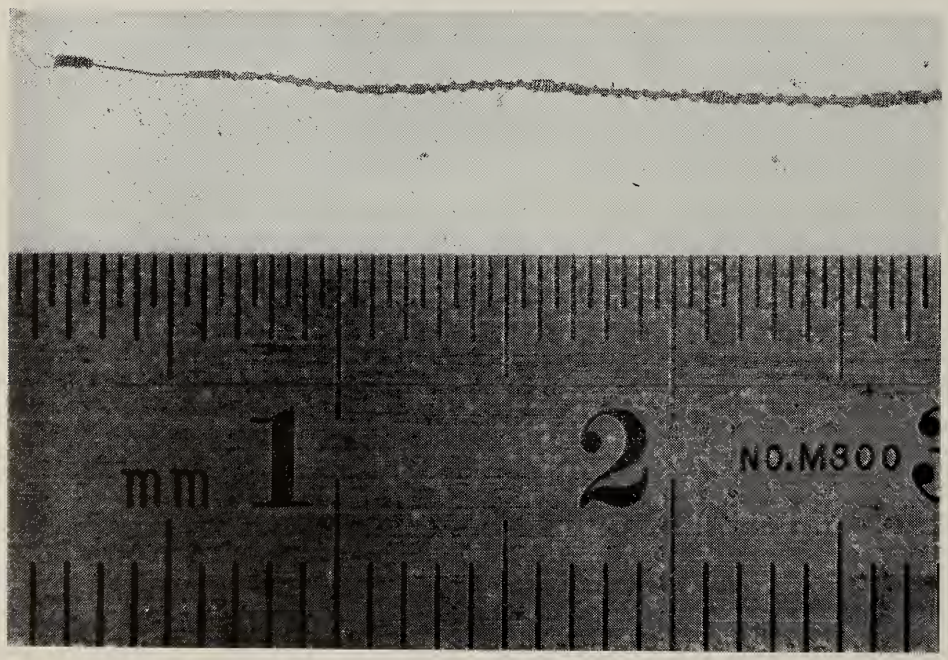



**FIGURE 10**

**DETAILED** photograph of the tip of a 6-contact cabled multi-electrode. The distal loop and each of the five closely wound sections is a separate contact. Each wire is .002" stainless steel insulated (except for the distal 1 mm.) with Teflon film.

## Summary

This brief article and accompanying bibliography has by no means covered the scope of present-day neurosurgery. It has attempted to highlight and to emphasize the classical but continuing problems in the field and to show that new thought is constantly being applied to old problems. It has also attempted to introduce some of the essentially new developments which are being designed to treat previously insoluble problems and which may not as yet be common knowledge.


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Review of the Literature
And Report of Four Cases

# Myelolipoma of the Adrenal Gland

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WEI-PING LOH, M.D. **
Gary

MYELOLIPOMA of the adrenal gland, a "tumor" composed of fatty tissue and myeloid and erythroid elements, is a rare lesion usually found incidentally at autopsy. In a review of the literature the writers were amazed by two unique cases which are worth summarizing in the following paragraph.

Dyckman and Freedman[1] in 1957 described a myelolipoma weighing 1,000 grams and measuring 16.0 x 13.0 cm. in a 47-year-old male who developed a sudden abdominal pain in the right upper quadrant which lasted five days. The pain was attributed to the rapid increase in its size due to hemorrhage into the tumor. More recently, Parsons and Thompson[2] reported a myelolipoma weighing 1,230 grams and measuring 25.0 x 13.0 x 12.0 cm. in a 51-year-old female complaining of malaise, anorexia, weight loss and abdominal discomfort. She had had a large, rounded, slightly tender mass at the right upper quadrant for two years. In each case, the symptoms were due to the size and position of the tumor. In both, x-ray findings were important in establishing the diagnosis.

Myelolipoma has been considered as a special type of extramedullary hemopoiesis. Extramedullary hemopoiesis is often found in various organs of the body, especially the spleen, liver, renal pelvis, adrenal glands and retroperitoneal, retropleural and perirectal fat, seemingly as a "compensatory process" due to destruction, dysfunction and "excessive demand" of the bone marrow. These are often associated with blood disorders, such as anemias and myelofibrosis. The presence of bone marrow in the adrenal glands has been attributed to heterotopia, myeloid metaplasia, ectopic bone marrow and bone marrow metaplasia. Oberling[3] in 1929 gave the descriptive term "myelolipoma" and his terminology has been adopted almost universally. Biressi[4] named them myelo-adipose structures; von Soos[5] called them "liporeticulo-endotheliomas." There is no reason to believe that these are true lipomas because of the absence of a capsule and fibrous septa and the presence of hemopoietic tissues.[6]

The etiology of the lesion is still unsettled. Gierke,[7] who reported the first case in 1905, suggested that the lesion is due to migration of bone marrow elements during the intrauterine development. This view is shared by Mieremet[8] and Wooley.[9]

Collins[10] suggested that adrenal cortical cells differentiate into bone marrow under optimal physiological conditions with the proper stimulus, since the adrenal cortex and bone marrow both originate from mesenchymal tissue. DeNavasquez[11] also believed in this theory. The rarity of this lesion and the fact that it does not occur in other more common sites of concomitant myeloid metaplasia and/or heterotopia seems to dispute this hypothesis.

Wooley[9] suggested two additional hypotheses:

(1) Embolism of bone marrow cells by way of the blood stream. This seems unlikely because of the absence of similar emboli in other tissues or organs; (2) Metaplasia due to irritation. This may be related to chronic irritation from infection or trauma with extravasation of blood into the adrenal stroma. This theory is shared by Gold-

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zieher,[12] Gossmann,[13] Herzenberg[14] and Newsam.[15] However, Gierke pointed out that metaplastic bone marrow in other organs is always associated with bone and for that reason, discarded metaplasia as an explanation of the myeloid elements.[6]

Extramedullary hemopoiesis due to anemia or some other special demand also has been suggested as a cause. The adrenals are rich in reticuloendothelial elements. Disturbances of hemopoiesis, which usually accompany extramedullary hemopoiesis, have been absent in all the reported cases of myelolipoma.

### Endocrine Imbalance and Stress

Plaut[16] suggested a relationship between myelolipoma and endocrine disturbances. Nine of the 100 cases he reviewed had significant endocrine imbalances, such as hermaphroditism, schizophrenic female intersex, pleuri-glandular disease, virilism, contracted adrenals, Addison's disease, extreme obesity, splanchnomegaly and Cushing's disease. Ricci and Calzavara[17] shared Plaut's view. McDonnell[18] reported a patient with diabetes and hyperthyroidism and one of three cases reported by Monus[19] had hypophyseal basophilism and functioning adrenal adenomas.

Selye and Stone[20] emphasized the role of stress as a cause of myelolipoma. In experiments on rats, they were able to produce lesions with typical bone marrow cell elements by transforming the entire zona reticularis and inner fasiculata of the adrenal glands by prolonged treatment with testosterone and crude anterior pituitary extracts. They pointed out the similarity between these experimentally produced changes and those occurring spontaneously in man, especially in patients suffering from "diseases of general adaptation," such as advanced carcinomatosis, atherosclerosis, the nephropathies and hypertension. McDonnell[18] reported that one of his four cases occurred in a patient with coronary heart disease and another in a patient with carcinoma; two of the cases of Monus[19] and the cases reported by Richardson,[6] Becher and Roach[21] and Parsons and Thompson[2] occurred in patients with cardiovascular disease. The patient reported by Holliday[22] died of bleeding gastric ulcer. Plaut[16] also noted the association of myelolipoma with fatal thermal burns and its increasing frequency in old age. Again, the rarity of myelolipomas and the frequency of the diseases listed by these authors makes it likely that the association is a chance occurrence, causally unrelated.

Any theory regarding etiology must explain the occasional occurrence of large neoplastic myelolipomas as well as the more common small focal lesions found incidentally at autopsy. None of the theories proposed to date can fulfill this requirement. None is entirely acceptable. It is possible that the lesion in all cases arises as a "simple choristoma." A great majority remain small and discrete. Under exceptional conditions not clearly defined, the lesion enlarges and becomes a true neoplasm. If these concepts are correct, an eventual case with malignant counterpart will be discovered. This theory appears to be more plausible in view of the fact that foci of extramedullary hemopoiesis, microscopic in size, are seen frequently in sections of adrenal glands selected at random. These may or may not be associated with aggregations of fat cells.

Plaut's[16] cases were between the ages of 17 and 93 years. He found none before puberty in the literature reviewed by him or in the files of the Armed Forces Institute of Pathology. Collins[10] reported Hirschfeld's case in a newborn infant who died with signs and symptoms of suprarenal insufficiency. It is evident that myelolipoma is not associated with any single disease.

von Soos[5] classified myelolipomas into two types: (1) Those characterized by yellow-orange color with preponderance of adipose connective tissue, and (2) those with dark red to reddish brown nodules due to predominance of cellular elements of increased bone marrow-myeloid elements and diminished erythroid components. It appears that the larger myelolipomas usually belong to the former and the smaller, especially the microscopic lesions, to the latter type. However, it is doubtful that this classification is of practical value. A simpler classification would be to divide

the condition into symptomatic and incidental. The former produce symptoms due to their size and require operative removal. These are very rare. The latter, by far the more frequent, are discovered incidentally at autopsy.

Approximately 140 cases of myelolipoma have been reported in the literature. The authors should like to add four cases of their own.

### Case Reports

*Case #1:* A 67-year-old white male was admitted to the SS. Mary and Elizabeth Hospital of Louisville, Kentucky because of sudden severe pain in his chest. He died an hour later. Death was attributed to extensive myocardial pathology. The adrenal glands together weighed 10 grams. Each contained several circumscribed but unencapsulated, soft, smooth, rubbery tumors measuring from a few millimeters to 3.5 cm. in diameter (Figure 1). The transected surfaces of these tumors were shiny and mottled golden yellow and dark brown. A thin strip of adrenocortical tissue could be seen at the periphery.

Microscopically, the tumors were composed of fat and hemopoietic elements surrounded by normal adrenal cortical tissue (Figure 2). The small nodules contained a considerable admixture of erythroid and myeloid elements, including normoblasts, myelocytes and megakaryocytes, while the larger were made up mostly of fat and recent areas of hemorrhage.

*Case #2:* A 54-year-old Negro female was admitted to the Methodist Hospital of Gary because of diabetes, hypertension and congestive heart failure. She died later of bronchopneumonia. At autopsy her left adrenal was found to contain a large, oval, well-demarcated and yellowish gray mass measuring 5.8 cm. in maximum dimension. The cut surface of the mass was bulging, slightly firm and glistening, with a number of red areas especially near the margins (Figure 3). Microscopic examination of the mass revealed an admixture of adipose tissue and myeloid tissue which contained areas of hemorrhage.

*Case #3:* A 59-year-old Negro male was admitted to the Methodist Hospital of Gary because of coronary atherosclerosis. His death was attributed to massive myocardial infarction. At autopsy his adrenals appeared to be grossly normal. Microscopically, one of the adrenals presented a small focus of adipose tissue and myeloid tissue at its cortico-medullary junction.

*Case #4:* A 70-year-old white female was admitted to the Methodist Hospital of Gary because of a cerebrovascular accident. Her death was attributed to cerebral hemor-




**FIGURE 1**
**GROSS appearance of the adrenals in Case 1.**

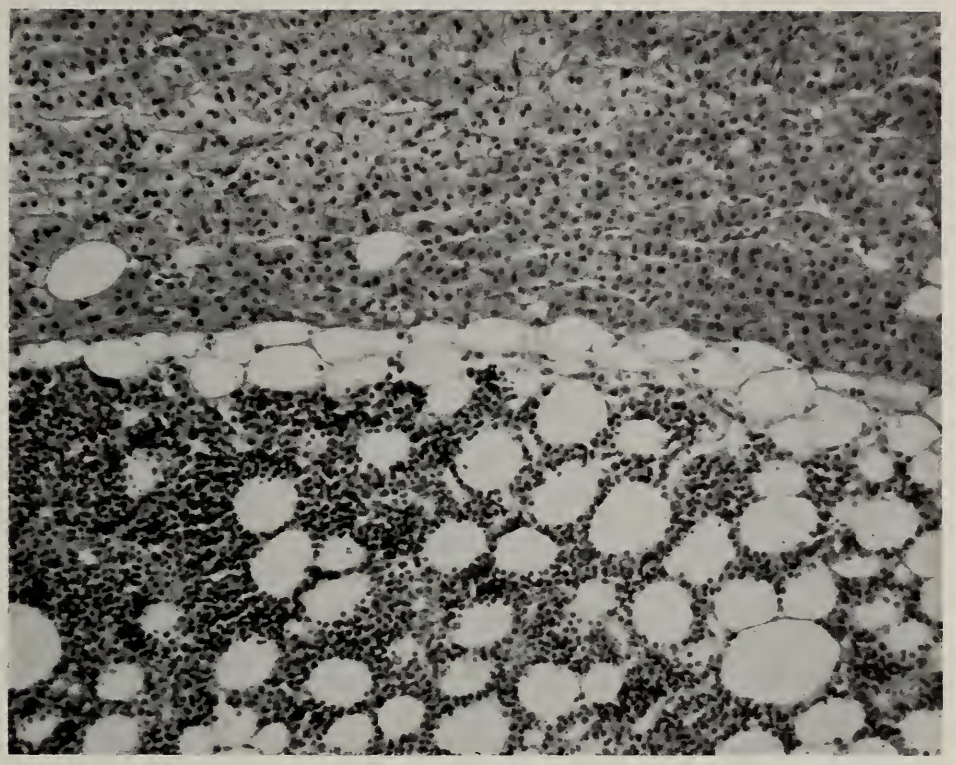


FIGURE 2
MICROSCOPIC appearance of the myelolipoma in Case 1 (100X). The upper half shows normal adrenal cortical tissue and the lower half shows hemopoietic tissue and fat cells.

rhage and acute myocardial infarction. She also had generalized arteriosclerosis, diabetes mellitus and possible hypertension. At autopsy her adrenals showed several nodules measuring from 0.2 cm. to 1.5 cm. in diameter. A few small hemorrhagic areas were also noticed. Microscopically, sections of both adrenals showed a combination of adipose tissue and hemopoietic tissue in the nodular areas described grossly. The nodules were in the adrenal cortex.

## Discussion

Myelolipoma of the adrenal is a bizarre lesion which presents a curious combination of hemopoietic and adipose tissue. The pathogenesis of the lesion is still unsettled. It has been attributed to extramedullary hematopoiesis, marrow embolism, unusual proliferation of reticuloendothelial cells in the adrenal and many other factors. In the majority of the cases reported in the litera-

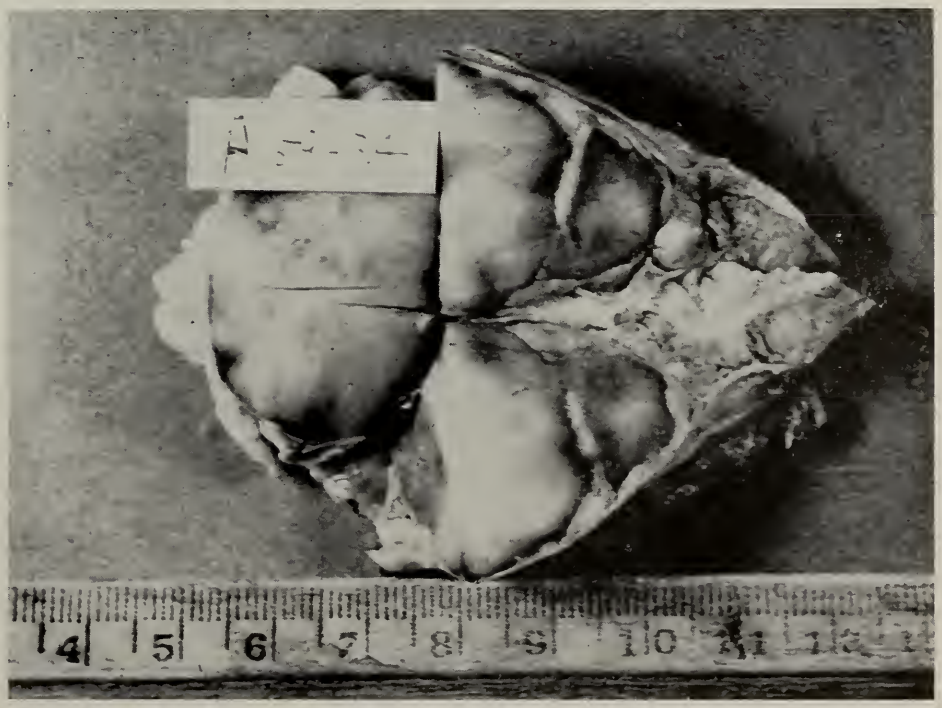



FIGURE 3
GROSS appearance of the left adrenal in Case 2.

ture, the lesion acted like a metaplasia rather than a true neoplasm.

The four cases of myelolipoma reported here provide the following information: First, the four cases were encountered in the relatively short period of less than three years and in a total of approximately 1,000 autopsies. This indicates that myelolipoma of the adrenal may not be as rare as we previously thought.

Secondly, Case #3 could have been overlooked if we had not made careful microscopic examination of the adrenal which was grossly unremarkable. This indicates that the lesion may be entirely microscopic or occult and could be detected only after careful microscopic examination of the tissues involved in the lesion.

Thirdly, two of the four cases (Cases 2 and 4) had endocrine disturbance in the form of diabetes. The authors share the view that there is a relationship between myelolipoma and endocrine imbalances as suggested by Plaut and others.[16-19]

Finally, all of our four cases had heart disease with or without hypertension and three of the four cases died of coronary heart disease. This picture appears to be compatible with Selye and Stone's emphasis on the role of stress as a cause of myelolipoma.[20]

## Summary

Myelolipoma of the adrenal is a rare lesion. Approximately 140 cases have been reported in the literature. The etiology of the lesion is still unknown. Many theories concerning the etiology are reviewed and discussed. It is suggested that the lesion arises as a choristoma. The authors present four cases encountered incidentally at autopsy in the relatively short period of less than three years. The lesions in these cases varied from microscopic size to 5.8 cm. in maximum dimension. The knowledge gained from our study of these four cases is presented.

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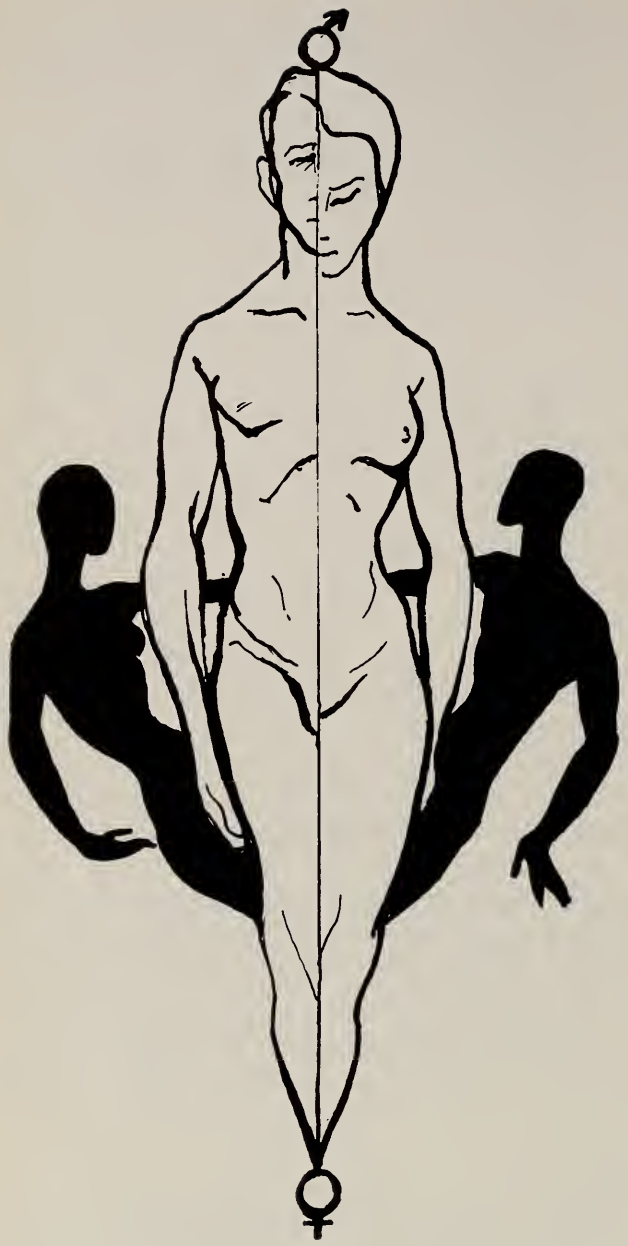
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## Double-Blind Method—Short Cut to Nowhere?

The double-blind method is an expensive device (expensive in terms of the cost in effort and of the low yield of information) used in the hope—often the vain hope—of obtaining a quick answer to the simple question of a drug's effectiveness in restricted circumstances.

It can be justified only as a means to be used by understaffed and overworked government agencies who have been given the impossible task (written into law by well-meaning but ill-informed legislators) of stating which drugs are effective and which are not.

In the evaluation of drugs, or of anything else in medicine, there is no substitute for extensive minute observations made closely, continuously, and for long periods under conditions as much like those of ordinary practice as possible.—M. D. Altschule, M.D., in *Medical Science* 15:12, (Dec.), 1964.



# The Case of the Tremendous Trifle

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

ALL MEDICAL STUDENTS are taught to take careful histories and perform thorough physical examinations; then, they are indoctrinated in the intricacies of performing a differential diagnosis: a *single* disease must be characterized by the summation of the presenting data. Medicine not being an exact science, now and then, an exception will arise to confound the teacher and delight his pupil. The casual, incidental finding can—with dramatic suddenness—amaze us all by becoming the tremendous trifle. *

Now Dirc Dosson (sounds Scandinavian, but is actually Swiss) was admitted to the hospital as one of those open-and-shut, sudden and obvious emergencies. He had been "not feeling well" for a couple of days. As he had assumed that he was developing a cold, he had taken a few aspirin and some lemonade laced with rum. A couple of generous jiggers of Scotch and a hot bath, later that evening had permitted a sound night's sleep. In the morning, feeling refreshed, he had sallied forth on his usual day's business. Shortly before the noon hour, he developed a "severe pain" in his left shoulder; the left wrist went "numb." He became dizzy and faint; a cab brought him to our emergency room.

The resident noted an acutely ill man, pale, perspiring and appearing to verge on collapse. Blood pressure was 90/60; temperature — 99° (orally); pulse—110, thready; heart tones: distant but regular. The doctor suspected an acute coronary occlusion. An E.K.G. taken stat. confirmed the presence of fresh myocardial damage: probably, subendocardial ischemia but, possibly, acute posterior wall infarction. The patient was taken to the intensive care unit and started immediately on the usual supportive measures: oxygen by nasal catheter, morphine for the pain, I.V. drip of glucose with added metaraminol, heparinization followed by dicumarol—all the rest of the standard cardiac regimen.

The serum enzymes were in conformity with the diagnosis; the white blood count was 16,000; the sedimentation rate — 38. The chest films, urine and other laboratory data were non-contributory. By the time

* With a bow to the shade of G. K. Chesterton.

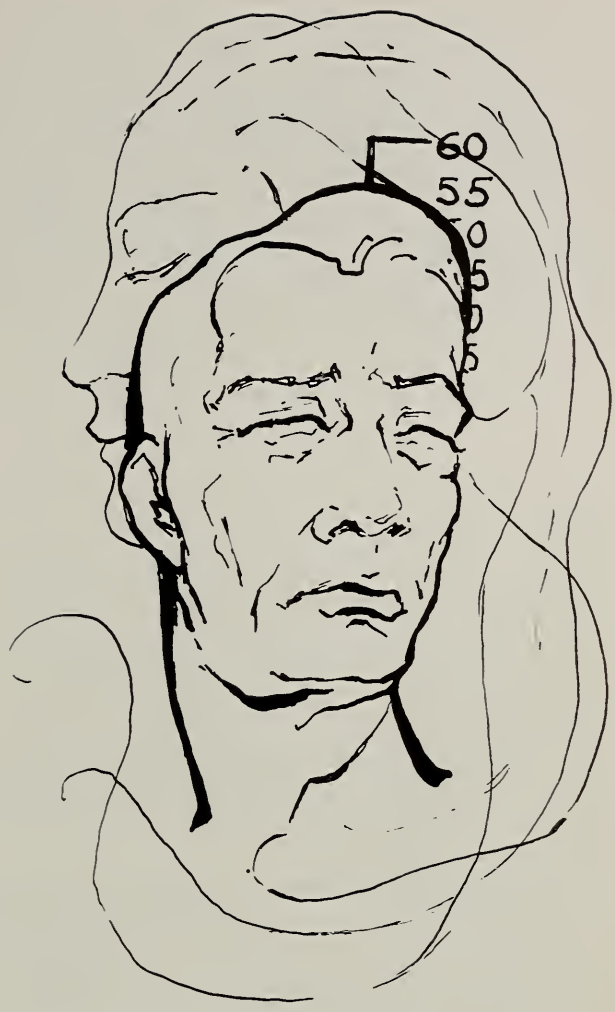
I saw the new admission later in the afternoon, he had responded most gratifyingly to the treatment. The blood pressure and pulse were back to normal; respirations were normally even; all the pain had disappeared. He appeared completely relaxed—almost drowsy. This seemed out of proportion to the mere 10 mgs. of morphine given hours before. I did remark to the resident that there was a puffiness of the face—most marked around the eyes. The skin was sallow and dry; a definite exophthalmos was noted.

The patient's progress was a model of the expected. The E.K.G. changes became more marked and then began to regress. On the second day, the temperature rose to 100° orally and then flattened to normal; the sedimentation rate and the w.b.c. also rose before beginning to fall. There were no more paroxysms of pain or paresthesias. In fact, he was unusually drowsy: frequently, the nurse would observe, "patient sleeping comfortably much of the afternoon. . . ."

There were no complications of any sort whatever. The enormous cholesterol—456—seemed a very satisfactory explanation for diagnosing one of those hyperlipidemias producing early atherosclerosis, etc., etc. Still, there was a vague unease in the back of my mind; there was the feeling of "something" wrong. The man's wife spent long hours at the hospital and from her, additional facts were gleaned as to the patient's background.

### An Energetic Tyro

Dirc Dosson had gone through a normal childhood in a sober, middle-class family. He had shown an early aptitude for study and hard work. It was at college that he met his future wife. He was a leader of his class both scholastically and socially. Rather short but powerfully built; well muscled and athletically lean—he had a rugged, square and very handsome face. Keen, intelligent blue eyes were set in deep sockets on each side of an aquiline nose marred slightly by the violence of a football collision. When he smiled, he flashed a dazzling set of teeth as his cheeks crinkled pleasantly and the outgoing personality




warmed you by its ambience.

The couple had dated a lot all through their college careers. They had planned to marry after his graduation. World War II had come along and he had gone abroad as a "tourist in uniform." This gave her ample time to also graduate and become a school teacher. They did marry the week he got out of uniform. He obtained a very fine job with a wholesale merchandising firm; she continued teaching. No children blessed their union; otherwise, they were very happy. They followed the all but standardized pattern of exurbanite life. Dirc did very well; the job became a position: he was definitely on the way to bigger and better things.

### An Exhausted Tycoon

Then, within the last three years or so, a gradual change in Dirc began to be apparent: first, to his wife and then to others. The still trim athlete began to fatigue more and more easily; trifles began to irritate



him to the point of nervous tics. Speech began to slur noticeably; he began to fall asleep in the middle of important business meetings—his boss suggested a vacation. Dirc went to a doctor—several doctors. After various and sundry consultations, the consensus was: an early climacteric. Mrs. Dosson did say that sex had all but vanished from their lives. Still, the family doctor was reluctant to embark on a course of androgen therapy. *

"Has Mr. Dosson had the facial puffiness for a long time?"

"No! As a matter of fact, the swelling around his eyes has begun to be prominent just within the last year."

Now I'll admit freely that I tend to overemphasize thyroidal endocrinopathies. Still, the emerging pattern seemed to clamor for further investigation. I asked for basal metabolic tests and blood was ordered drawn for a determination of the protein bound iodine. The BMR was -34% once and -38% when repeated. The PBI came back 0.6 the first time and an even more astonishing 0.4 when re-checked!

"Had Dirc's doctors ever performed these studies?" Unequivocally: "No!"

Of course, the status of the myocardial infarct was unchanged; its treatment remained as before. But, *very cautiously,* 30 mgs. of thyroid extract was added to the medications. After a week, the dosage was doubled. Of course, it is a supererogation to say that great care has to be exercised when administering this hormone to the severely hypothyroid patient *especially* in the presence of recent coronary thrombosis. In fact, very eminent authorities advocate *total* thyroidectomy in people with severe stenocardia. They believe that such surgery may *prevent* coronary occlusions. A lengthy pro and con discussion will serve no useful purpose here. The reader can be referred to monographs such as those by Williams, Stanbury and many others. The need for making haste slowly is only too obvious.

Just as obvious was the fact that the almost casual incidental finding had become the truly TREMENDOUS TRIFLE quite overshadowing the coronary thrombosis that continued on its most placid, totally uncomplicated course.

### Vigor Revived

By the end of a month, the patient's physique AND personality began to alter visibly. The puffed dry skin on the face had returned to its normal gloss—the edema had vanished. The patient no longer spent so much time dozing; he was alert: when he spoke, the words were enunciated crisply —the eyes showed their former keen intelligence. The cholesterol was re-checked: it was down to a normal 226! Of course, we all remember that, not so many decades ago, thyroid function was best gauged by the cholesterol index: the higher the reading, the more sluggish the thyroid—and vice versa. While the debate about the role played by cholesterol in the genesis of

* Many monographs can—and have—been written on the sex hormone approach to the problem of the climacteric. Somehow, within the framework of the mores of our society, women seem to have become reconciled to having the "change." An increasing number of practitioners give menopausal women estrogenic preparations not only to control overt psychotic behavior in the obvious 5 to 10% but also to intensify the anabolism that helps prolong more youthful animation and appearance.

Men still bridle at the mere thought of anything that challenges their virility. The MALE climacteric is considered a rarity (?). Hot flashes, vasomotor instability, loss of sexual drive, irritability and fatigue—even excellent physicians go out of their way to ascribe the symptoms to everything but the catabolic consequences of the loss of testicular function. Possibly, the notoriety of such blatant quackery as goat gland injections and simian testicular transplants has made reputable doctors quail at even the appearance of emulating Hoxie and Woronoff.

Overall, however, it is my impression that the trend in the profession today is in the direction of treating women AND MEN for these deficiencies as they do any other endocrine malfunctioning.

atherosclerosis and intravascular clotting is still far from having come to a definitive conclusion, let us bear in mind that this is just one of the points raised by the opponents of thyroidectomy as a prophylaxis for stenocardia. . . .

Be all that as it may, Dirc Dosson is back on the job. He has regained his pristine drive and vigor; he is again on the way to the top. After lengthy consultations, the family physician, I (and his wife) agree that no sex hormone is needed. Never have I seen more gratifying response to so small a smidgin of such inexpensive, simple medication.

Let us desist while we are still ahead! ◄

1270 Fifth Ave.,
New York, N. Y.

## About Our Cover

A fee schedule in modern medicine would really create havoc!

But in 1859, the LaPorte County Medical Society adopted the fee bill on this month's cover and pledged themselves "to adhere to the above list of prices in our charges."

For a natural case of obstetrics in town, the fee was $5.00. For extreme cases, requiring forceps, turning or extracting with crotchet, the fee was $10 to $20.00. Of course there were the "extras"—when the midwifery took place in the country, mileage was added and mileage in cases of obstetrics and consultation were one-half that of ordinary visits.

The most expensive item on the schedule was $100 to $200 for lithotomy. Among the cheaper rates were vaccination, 50¢; opening an abscess and venesection, 50¢ and detention, per hour, 50¢.

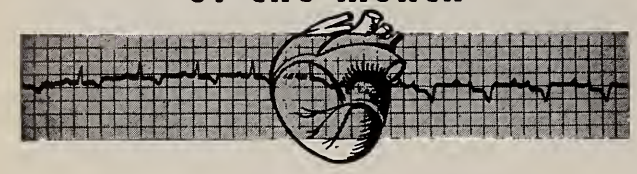
The fee schedule came to our attention via Dr. G. O. Larson, of LaPorte. Miss Mayme Hickman, a nurse, showed it to Dr. Larson and he thought it was interesting enough to submit to *The Journal*.

Miss Hickman was employed in Dr. J. H. William Meyer's office in LaPorte for many years. After his death, in clearing out his effects, she found the schedule. Dr. Meyer was born in Hanover, Germany, in 1853. He came to America in 1871 and after clerking in a dry goods store for a time, he began the study of medicine in the office of Dr. Tomkins Higday.

He later interned at Rush Medical College and was graduated from there in 1876. After serving for 18 months as house physician and surgeon at Cook County Hospital in Chicago, he went to Berlin for further study. After his return, he began his practice in LaPorte. A few years later he again went to Europe in 1886 and stayed a year studying in Vienna and Heidelberg. He returned to LaPorte in 1887 and resumed his practice, which continued until his death in 1925.

Our thanks to Miss Hickman and Dr. Larson for making the fee schedule available to us.—J.F.S.

# Electrocardiogram
## of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Nonspecificity of the ST-T Segment Changes*

*CHARLES FISCH, M.D.*
*Indianapolis*

THE NONSPECIFIC NATURE of the ST-T segment depression, T wave inversion, ST-T segment elevation and particularly their occasional labile and benign characteristics has been the subject of voluminous literature. Yet one frequently encounters individuals who are cardiac invalids simply because of misinterpretation of the ST-T segment change. Every effort should be made to find out if the "abnormal" T wave is labile, thus of little or no clinical significance.

Simple procedures which may affect the polarity of the T wave are (1) recording the ECG under basal condition, (2) administration of glucose, (3) ingestion of 45-60 mEq of K, (4) hyperventilation and (5) administration of atropine. If coronary cineangiography is contemplated, it should not be recommended solely on the basis of an abnormal ECG and in the absence of symptoms suggestive of heart disease.

Figure 1 is an example of an abnormal ECG in the absence of heart disease. The patient, a 25-year-old male, was seen because of vague chest pains which were difficult to interpret. For this reason he was subjected to coronary angiography which visualized a normal coronary tree. The ECG abnormalities include slightly elevated S-T segments in leads II, III, AVF, V-5 and V-6 with an isoelectric T wave in I, AVF, V-6 and inverted T wave in III.

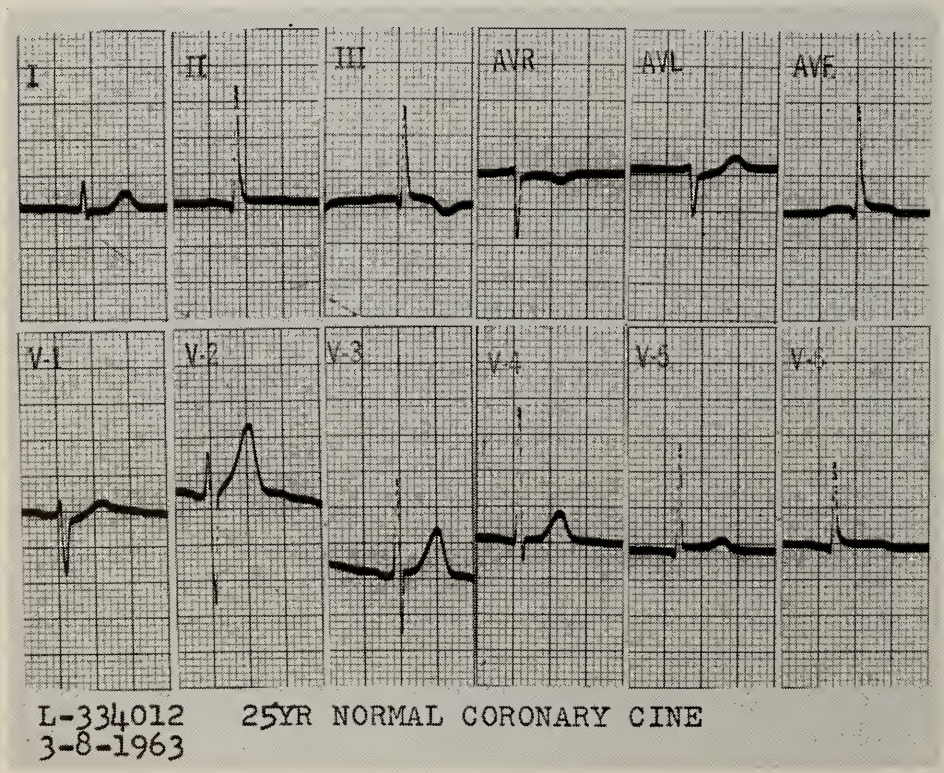



**FIGURE 1**
**ABNORMALITIES of the ST-T segment may be seen in leads II, III, AVF, V-5 and V-6.**

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Lymphography

PATRICK A. DOLAN, M.D. *
*Indianapolis*

A 61-YEAR-OLD white male was initially seen in April, 1961, complaining of abdominal pain and fatigue. Exhaustive clinical and laboratory investigations, including extensive radiographic studies, showed only slight liver enlargement which was thought to be due to acute cirrhosis and generalized pulmonary emphysema. His symptoms continued until December, 1962, when his malaise increased. Further investigation at that time, including skin and bone marrow biopsies, contributed no additional information. Three subsequent hospital admissions were necessitated by increasing anorexia, weight loss, intermittent fever ranging up to 103° and pain which was now predominately located in the back and lower limbs. It was obvious that the patient was very ill.

Gastric carcinoma was the admitting diagnosis on 8-15-64; occult malignancy was among the provisional diagnoses entertained. There was no lymphadenopathy nor other palpable masses. Laboratory studies were not informative. Among the roentgenographic examinations reported as essentially negative were chest studies, a cholecystogram, intravenous and retrograde pyelograms (Figure 1), an upper gastrointestinal series and a barium enema. A celiotomy was considered, but after some discussion, lymphography was performed instead.

The lymphogram showed extensive lymphoma in proximal femoral, iliac, retroperitoneal, mediastinal and left supraclavicular nodes (Figure 2). The appearance was typical of lymphoma except that the lymph node enlargement was less than that usually seen in such extensive disease. The radiographs indicated that biopsy of a 3 cm. proximal left femoral node (which was impalpable even after the lymphographic opinion was rendered) would prove effective and this was carried out. The patho-



**FIGURE 1**

**INTRAVENOUS pyelogram, July, 1964, reported as showing no conclusive evidence of abnormality.**

* Radiologist, Methodist Hospital.

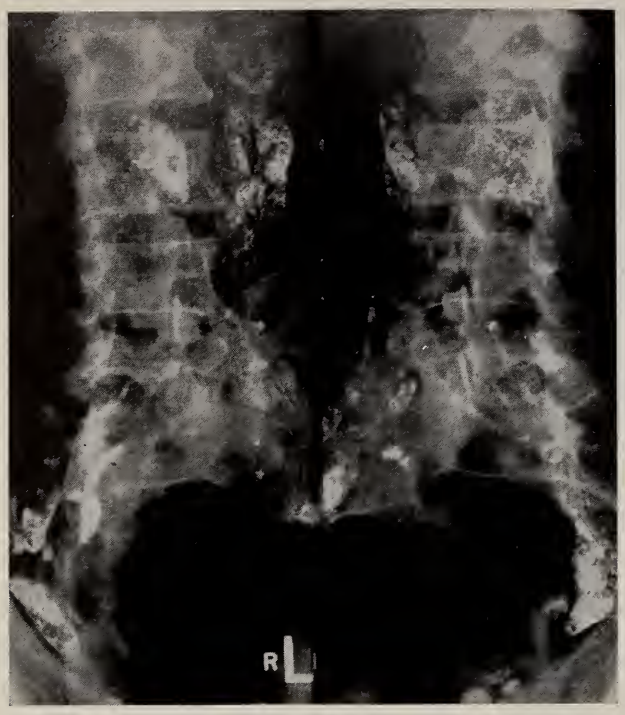



**FIGURE 2**
**RETROPERITONEAL lymphogram, August, 1964, showing extensive lymphoma. All nodes demonstrated on these oblique views are involved.**

logic report was Hodgkin's granuloma.

Appropriate treatment (including Velban† and uracil mustard) resulted in marked improvement in the patient's condition. The shrinkage of the opacified lymph nodes on the lymphogram follow-up films paralleled this improvement. He was discharged, and is still markedly improved four months after the diagnosis was made and treatment initiated.

### Value of Lymphography

This case illustrates one of the more dramatic ways a lymphogram can provide information of extreme importance in the diagnosis and treatment of disease. When other more standard investigations fail, the obscure clinical problem may very easily yield to lymphographic study. In addition to indicating the pathologic diagnosis (which should always be confirmed histologically) the study will, under certain conditions, render unnecessary the even more expensive and traumatic diagnostic surgical procedures available.

The appearance of lymphoma on the lymphogram is usually typical and the accuracy of the procedure fairly high, probably over 90% in revealing such disease. Identification of the subgroup within the lymphoma classifications on the basis of the lymphographic appearance of the nodes results in a radiographic-histologic correlation of 60 to 70%. In addition to rendering valuable service in the solution of difficult diagnostic problems, the lymphogram can alter the staging of lymphomas by demonstrating unsuspected disease in patients exhibiting localized peripheral lymphadenopathy. Opacification of the lymph nodes persists in diagnostic degree for as long as six months so that treatment effects can be assessed objectively. The procedure will also allow detection of metastases, particularly in patients suffering from such primary lesions as tumors of the genitourinary tract, malignant melanomas, other neoplasms of the upper and lower limbs or carcinoma of the breast. It can be used to assist in, and assess the completeness of, lymphadenectomy.

Lymphography is a radiographic procedure and can be incorporated into the group of special investigations done in the radiologic department of any hospital without difficulty. The cannulation of a lymphatic and injection of contrast medium requires no special, expensive equipment. With interest and experience, any radiologist is capable of performing the procedure and no unusual skill is required. Side effects, as with any of the examinations in which foreign material is injected, are to be guarded against, but have offered no great problem in more than 300 examinations; indeed, most of these examinations were done on an out-patient basis. ◄

† Eli Lilly and Company, Indianapolis, Indiana.

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of the INDIANA STATE MEDICAL ASSOCIATION

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# Great American Tragedy

HAS SOMEBODY declared a "Hate Your Doctor" month?

In recent weeks we have noticed frequent letters in the Indianapolis and Louisville dailies criticizing, browbeating and demeaning the doctors of America.

It seems to us there are too many of these letters to dismiss them as mere coincidence. Is somebody behind an organized campaign to discredit the nation's medical men?

We would hate to think so. Yet we would prefer to believe that these letters are being pressured from a handful of crackpots than to believe that they represent the general attitude of the American people. We just don't believe that they do.

After all, America's free enterprise practice of medicine provides far and away the finest health care of any nation in the world and, by the same token, the finest health care we have had in history.

These letters to which we refer purport to be written in support of Medicare. Apparently, the American Medical Association's firm opposition to any form of socialized medicine has stirred up a hornet's nest among the short-sighted who want everything, from cradle to the grave, to be provided.

The letters we have read invariably degenerate into a personal attack upon doctors individually. They cite instances of long hours in waiting rooms, of doctors who were unavailable in emergencies, of bills for treatments that turned out to be ineffective. Medicare, they say, will take care of all this and much more. They chortle vindictively that now at last the haughty doctor is going to get his comeuppance.

It is only human nature that there should be a certain amount of envy that the average doctor these days is somewhat more prosperous than the average printer or bricklayer or feather merchant. We do not share such envy. We rejoice that this is so. We would not have it otherwise.

Without the prospect of adequate reward, why should a qualified young man undertake the long, rigorous training that leads to an M.D. degree and the establishment of a practice? The opportunity for service to humanity should also be a factor, and undoubtedly is, but we cannot understand anyone who begrudges above-average compensation to a man who dedicates his life to alleviating pain and suffering among his fellow men.

We do not pretend that doctors, individually, are perfect. They are subject to error. They get tired like you and I. Sometimes their days cannot be stretched enough to give adequate attention to every desperately sick person on their list. Sometimes, we suppose, one slips through medical school without being adequately prepared to practice. And, as in any other large group of humans, when judged on personality, morality, and integrity, occasionally you will find a clinker.

The basis for any current dissatisfaction with the medical profession, we think, is that people expect too much from their doctor. They think that he has within his power, if he will but make the effort, the gift of life itself.

But he is not a magician. At best, all he can do is to prolong life. Maybe for hours, maybe for days, maybe even for years. Probably the doctor himself is too busy to think of it this way, but the cruel fact is that every case he undertakes he is bound to lose in the end, assuming he remains in practice long enough and the patient remains with him. Whether the case lasts for a week or for 40 years, the end is inevitable.

The American medical profession today is based on competitive free enterprise. In any line, free enterprise is more efficient and more beneficial to the consumer than government operation of the same activity. Let's have no quibbling about that statement. Either you believe that or you believe in socialism.

That is what the medical profession is faced with in Medicare. Proponents of Medicare say that it is not really socialized medicine because it is to be worked through Social Security and not all the people will be eligible for it.

But when we citizens of 25 or 35 or 55 are to be taxed to pay the medical bills of certain other citizens, how can it be called anything but socialized medicine?

We are not heartless when it comes to providing care for the needy sick, whatever their age. And we are not ashamed of the job America is already doing in this respect. Charity hospital and clinical service is available. Public welfare has provision for the medical needs of the indigent. The Kerr-Mills law, which goes into effect in Indiana Jan. 1, provides medical care for those elderly people, whether or not on Social Security, in cases where their medical expenses would be a burden.

Medicare adds to the Kerr-Mills list those other people on Social Security who have ample resources to meet their own doctor bills. This glaring justice can be remedied in only one way: Expand Medicare to include every citizen, regardless of age or need. Once the taxpayers realize what has been unloaded on them, that will be the irresistible demand. And then we will have total socialized medicine.

This is what the American Medical Association has opposed in its fight against Medicare. They, who know more about it than anyone else, have pointed out that socialized medicine will lower, not raise, the medical care available to the American public. The cynical, vote-hungry politicians have dismissed their protests as coming from a group of greedy, privileged, self-seeking men.

In our life we have known several doctors, three or four of them intimately. We have never known one we thought would put his personal profit above the welfare of his patient. When the doctors say that socialized medicine is bad for the public, we believe them implicitly.

Medicare has a high priority under the Great Society program. Probably no American president ever has had a congress under such complete subjugation as Lyndon Johnson will have the one that convenes in January. What Lyndon wants, Lyndon will get. Don't bother to write your congressman or senators; they are committed to give Lyndon anything he wants.

Passage of Medicare will be one of the major American tragedies. It is only a step, but history has proven that there is no turning back once we start toward socializing any phase of the economy.

Once it is in effect, the advocates of Medicare are in for a sad disappointment. They are going to find a vast difference between consulting a doctor who is working for the patient and a doctor who is working for the government.—*Paoli Republician, Dec.* 15, 1964.

# Hyperbaric Oxygenation

PRIOR TO 1956, the administration of oxygen under increased pressure was not considered desirable, nor more effective than oxygen at normal atmospheric pressure for two reasons. One reason was that most of the experimental work was done at pressures below two atmospheres. Today we know that, except for the treatment of carbon monoxide poisoning at two atmospheres, all other amenable conditions respond only to pressures as high as three atmospheres.

The other and more persuasive reason was that all observations indicated that persons in good health and some laboratory animals developed alarming symptoms of oxygen toxicity, even at pressures below two atmospheres and for periods of exposure of less than two hours.

Providentially, it has now been shown that, for some reason, patients with valid indications for hyperbaric oxygen will tolerate pure oxygen administered in an environment of air under three atmospheres of pressure for as long as two hours and as often as twice a day.

It would appear that the benefits obtained by hyperbaric oxygenation (HBO) in gas gangrene would be due to a bactericidal effect of oxygen upon the anaerobic Clostridia. However, it is known that viable organisms may be obtained from the tissues of recovered patients and recently it was demonstrated that the oxygen performs its lifesaving mission by preventing the formation of the alpha toxin. This is one of the effects observed at pressures of three atmospheres, but not at two.

Since patients may be subjected to three atmospheres pressure of oxygen for two hours twice daily and no more, it is remarkable that the toxin eliminating effect is sufficient to allow the patient to overcome the infection.

In addition to the saturation of the hemoglobin and consequent drenching of all the tissues with oxygen, HBO makes it possible for any circulating fluid to carry oxygen in physical solution. This affords a great advantage in the treatment of carbon monoxide poisoning where the altered hemoglobin cannot carry oxygen. The efficiency of the physical solution oxygen-carrying system may be demonstrated by exchanging a laboratory animal's entire blood supply for a non-hemoglobin infusate, maintaining the animal under HBO at three atmospheres, later returning the original blood and observing a return to complete health.

In addition to the poorly understood toxic properties of oxygen under pressure, there are many other risks associated with HBO. Decompression of the patient does not involve any possibility of nitrogen bends, but this hazard is a real one for the attendants who occupy the pressure vessel and breathe the air under pressure.

The patient and attendants are all subject to pressure effects due to entrapment of air or oxygen in the paranasal sinuses or the middle ear. Decompression of these cavities is usually accomplished by repeated swallowing or by the Valsalva maneuver, but in the case of an unconscious patient, the problem is important enough to warrant bilateral myringotomy prior to treatment by HBO.

The fire hazard is also many times that encountered in standard oxygen tents. All combustible material must be reduced to a minimum and control of static and electrical equipment sparks is especially important.

The excellent curative record of HBO in anaerobic infections, carbon monoxide poisoning, open heart surgical procedures and in recoverable circulatory difficulties; and the promise of success for its use in coronary artery disease, vascular spasm, deep vascular shock and respiratory distress syndrome of the newborn, prompts further investigation into its mysteries.

# We Need Your Opinion

HOW WOULD YOU improve *The Journal?* All members of the Indiana State Medical Association are asked to write their suggestions on the reader survey form

opposite page 94 in this issue and assist the staff in modifying the content and format of *The Journal* so that it will serve the membership in the best possible manner.

Medical journalism is a constantly changing medium. The science of medicine and the art of its practice are constantly changing. The basic editorial policy and the various features of *The Journal* have been established in the past in response to the wishes of the readers. Modifications have been made as a result of periodic readership questionnaires.

The time has arrived for another such survey. Decrease in advertising revenue in the past few years has made smaller issues necessary and our limited space for scientific and other features has therefore become more valuable. We would like to know what the physicians of Indiana desire in their journal so that the limited space we *do* have may be utilized in the most advantageous manner.

The economics of medical journalism is that advertising revenue provides most of the financial muscle. The economics of advertising is that advertisers favor publications with the largest readership. Large readership comes to those journals which are filled with what the readers want.

When the readers express their desires, and when the journals are constructed to these specifications, more advertising revenue results and the journals are able to provide more of the type of material that is wanted. And no small part of what is gained by advertising in the pharmaceutical and medical product fields is a treasure of information on new drugs and new products. Pharmaceutical advertisements today are equivalent to a preview of the pharmacopoeia for next year.

Good medical journals make good advertising media. Good advertising and good advertising revenue make good medical journals.

Vote for a better state medical journal. Let us know what you want. If the time does not permit filling in the questionnaire, tear it out and mail it in blank as a vote of confidence in your journal.

## Editorial Notes...

**Hyperbaric oxygenation side effects have been studied at Duke University by observing and questioning 52 individuals who have worked in high pressure chambers.** The most common symptom, by far, was ear or sinus pain. Forty-seven percent of the staff noticed this at one time or another during compression and 28% noticed it at least once on decompression. Only one person found it necessary to discontinue work under pressure.

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**Total borrowing from the AMA-ERF Loan Program is now slightly in excess of $17 million.** This fund, which is supported by a cash reserve, loans $12.50 for each dollar contributed. Since the program started 28 months ago, 10,398 individuals have received loans. Of these, 488 have completed their medical education and are in the process of repaying while an additional 139 have paid their loans in full. It is estimated that by 1970, the loan program will be self-sustaining. When the fund reaches this state, there will be $6 million in the reserve, about $3.7 million more than at present. The response of physicians and private industry toward building up the reserve has been and continues to be very generous.

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**Special educational medical and nursing closed-circuit television shows may be transmitted to hospitals soon.** Hour-long programs originating in medical centers will be transmitted by AT&T long line cables directly into the participating hospitals. Various pharmaceutical firms are planning to underwrite the major expenses of production and hospitals will pay the cost of local hookups to television lines. The programs will be televised originally about once a month, later once a week. Since the hospital hookup cost is by the month, the more frequent programs will be less expensive for the hospitals.

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**The experimental study of retail pharmacies as health education centers by the use of educational booklets published by**

**voluntary health associations was reviewed recently in** *The Journal.* The American Pharmaceutical Association announced recently that the program would become functional soon with the literature display racks going to participating pharmacies. The early response by pharmacists to the program is reported as very encouraging.

**New word—kryptonate.** A kryptonate is a solid which has been made slightly radioactive by impregnation with the radioactive gas krypton-85. Kryptonation is begun by bombardment of a material with ionized krypton gas or by diffusion of the gas into the material under high temperature and pressure. It is expected that it will be extremely useful as a tracer substance. It has a low-energy beta emission; virtually no gamma activity; diffuses rapidly when released and does not enter into the physiological cycle. So far the process has been utilized in metallurgical and chemical research; no applications to biological research have been announced.

**The thalidomide experience, aside from the horror inherent in the event itself, produced two disquieting conclusions.** One was that it would be necessary in the future to test every new drug and in fact some older drugs for teratogenic effects. The even more disquieting but corollary fact was that thalidomine, except in enormous doses, does not produce any untoward effects in ordinary laboratory animals. Scientists of Chas. Pfizer & Company have announced that they have produced abnormalities strikingly similar to those in humans by administering therapeutic doses of thalidomide to monkeys. Much more investigation is required to test many drugs known to be safe in man, to be sure that the monkey test does not produce false positive results.

**The number of foreign-trained physicians licensed in the U.S. in 1963 was equal to the output of 14-16 average sized U.S. medical schools.** In that year, 1,451 of the 8,283 new licentiates were trained abroad. An even higher percentage (19.7) of the licentiates in both 1959 and 1961 were graduates of foreign schools. Since 1950, the number of licentiates has increased by about 2,000 and, on the average, 1,000 of these have received their M.D. degrees outside the United States and Canada.

**Closed chest heart massage and artificial respiration as resuscitative measures are now well established as to technic and reliability.** Many forms of what would otherwise be sudden death are amenable to emergency treatment. Ventricular fibrillation due to coronary thrombosis or electric shock and cardiac arrest due to drowning are the more common conditions in which prompt action may save life. Many times the prompt action must be prompter than can be provided by emergency fire or police vehicles or ambulances. Therefore, more people should be trained in closed chest resuscitation.

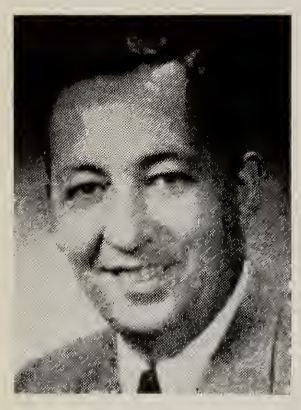
**The mortality rate for diabetes has risen the world over in the past decade, in some countries by as much as 50%.** When analyzed by age groups, it is noted that the mortality for those under 25 has dropped sharply, and the rate for ages 25 to 44 has been considerably reduced. These are the ages in which acidotic coma is the principal serious complication. In the older age brackets, it is difficult to assess the data. Older diabetics die usually of vascular complications and it may be that physicians are now more apt to list diabetes as the cause of death whereas in the past, vascular diseases were listed first and the underlying diabetes either was assigned a secondary role or was not mentioned.

**Intensive care is possible in "intensive care units" partly because vital signs are intensively observed and recorded.** Electronic devices to monitor the patient's condition are becoming more numerous and more automatic. The medical department of the VA is now training nurses especially in reading and translating the graphs and other recordings obtained electronically. The VA is also utilizing an electronics engineer in a special instrument testing setup. Blood pressure, skin temperature, acid-base balance and constant electrocardiographic tracings are the standard data now being tested. More are expected later. ◄

# President's Page

The holidays are over but a happy and prosperous new year wish is always the first order of business in a new year.

The Indiana delegation went to the AMA Clinical session full of enthusiasm but with feelings of cautious confidence. We returned somewhat dejected but aware that the American Medical Association political scene is not an arena for novices, mavericks or amateurs. Don Wood was an excellent candidate and everyone agreed that his personal popularity and his many friends were the greatest sources of our voting strength. This was a tribute to Don and to the state of Indiana. We are proud of Don and Betty Wood; they were wonderful campaigners and gracious losers.



The ISMA is indebted to our state university president, Dr. Elvis Stahr for his excellent address at our Indiana breakfast and for his cooperation and enthusiasm in our campaign. President Stahr was indeed an excellent asset. Frank Jones of the I. U. Medical Alumni Association worked vigorously and tirelessly in our hospitality headquarters. Frank also brought our entertainment from the I. U. campus—Lorna Dallas and Jim Bean. They were hits.

Also our gratitude goes to other organizations in our state who assisted us in many ways, and to Art Loftin, Executive Secretary of the Marion County Medical Society for his valuable assistance.

We can be proud of our delegates: Drs. Harold C. Ochsner; E. S. Jones; Francis L. Land; Guy A. Owsley; Jack E. Shields; James H. Gosman; Robert M. Brown; Frank H. Green; Wm. B. Challman and John M. Paris; and our trustee, Dr. Lester Bibler, whom we all recognize as outstanding representatives of the ISMA.

Jim Waggener, as always, and Ken Bush had everything ready from mustard and Hoosier ham to appropriate souvenirs for the delegates. Mrs. Waggener, Norma, lent our wives and others a helping hand too. Behind every man is a partner, his wife. The women stood by the hour as wonderful hostesses and waited with patience for their husbands who spent hour after hour in meetings and caucus sessions. Thank you girls!

The AMA today has many facets of operation and activities for the present and future. It is important that we send informed, knowledgeable delegates and officers to its sessions. With this thought in mind, your president is going to recommend that in future sessions, we encourage members of the Council and chairmen of commissions to attend these meetings. It will be one of the many means we can use to increase the knowledge of our members.

We are sorry we did not have a winner but it is nice to have Don back home in Indiana.





# LOMOTIL®

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride . . . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

- lowers motility promptly
- relieves spasm promptly
- stops diarrhea promptly

Lomotil fulfills the first order of treatment in most patients with diarrhea — prompt symptomatic control.

Pending discovery of the cause, early cessation of diarrhea is almost always urgently indicated. Prompt symptomatic control averts distress, dehydration and, frequently, severe exhaustion.

Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

## dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

## cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE

*Research in the Service of Medicine*

# The Woman's Auxiliary

## REPORTS TO ISMA

During recent visits to the county auxiliaries, the most persistent question has been, "After the election, what?" The lastest national auxiliary *Bulletin* which goes to every member has some answers. Briefly, it tells us:

If the election results did not meet with our approval, begin working now—there will be another election in just two years and the men elected to these offices have more direct control over our daily activities than the President of the United States has ever had!



Our auxiliary legislative chairman will keep us informed with suggested plans of action but there is much that each physician's wife can do as an individual.

Continue to write your Congressmen, organize a "Precinct Action Course" or continue with this course of study.

Get acquainted with your state representatives and give them the courtesy of letting them know your opinions.

Join AMPAC and your state PAC (I-HOPE). If you already hold a membership, renew it for the coming year. Contributed now, it gives the directors of these funds a clear picture of how effective they can hope to be in getting sympathetic candidates elected the next time around. In addition, it provides them with impressive ammunition with which to back their arguments when they encourage a good man to enter an elective race.

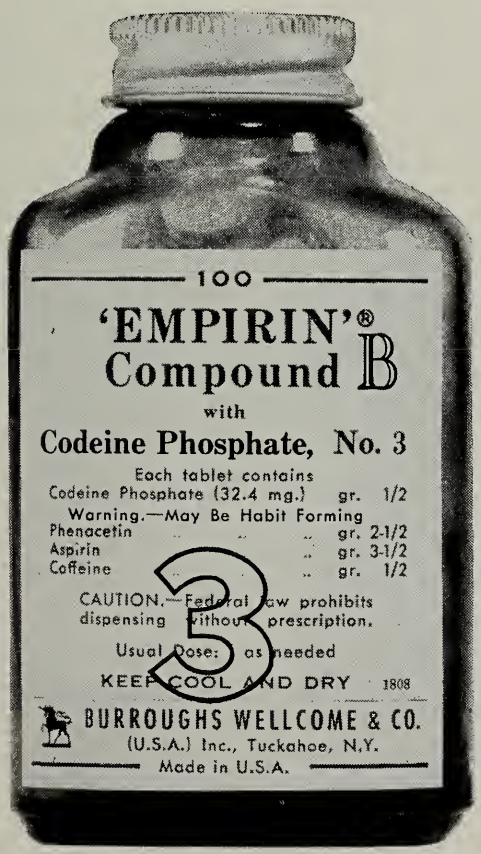
Our auxiliary should work closely with the state and county medical societies on health matters which will come before our state legislature. Particular attention should be given to the improvement of existing Kerr-Mills plans and other health proposals which our legislature will consider. We were advised to check with our medical society and find out how we can be of assistance in securing passage or defeats of a specific proposal.

Political action and legislative action go hand in hand, for one is impossible without the other. Whether we are satisfied with the status quo or wish to bring about a change, we still face the challenge of work. It can never be "all over" as long as there is another campaign just two years away!

Bea Shields

# Your patients will say "The Pain Is Gone" when you prescribe

# 'EMPIRIN'® COMPOUND with CODEINE gr. 1/2




'EMPIRIN' COMPOUND with CODEINE gr.1/2 (No. 3)
KEEPS THE PROMISE OF PAIN RELIEF

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

A Critical Look At
Indiana's Worst Disaster

# The Indianapolis Coliseum Diaster*

**Dateline: 11:04 p.m. October 31, 1963**

It had been a trouble-free Halloween evening in Indianapolis. The city's 500,000 citizens were protected on this night by augmented police patrols assisted by 200 Civil Defense policemen and 16 radio cars of the amateur "Goblin Patrol." A cold drizzling rain had kept vandalism to a minimum. In the city's eight hospitals, the evening routine prevailed and it was shift change time in the hospitals and at the police departments.

**11:06 p.m.** "The Coliseum Just Blew Up." This frantic message, mingled with background screams and wails of the injured, shocked the fire dispatcher and raised the curtain on the worst disaster in the history of Indiana.

Four thousand, three hundred and twenty-seven spectators were watching the opening performance of "Holiday On Ice of 1964." The finale, a "Mardi Gras" number, had just begun. Suddenly an entire section of seats 50 feet long erupted in a volcano of somersaulting bodies, seats and huge pieces of concrete and steel. Spectators and masonry were blown upward and forward onto the ice and onto people in the sections in front of them.

People across the arena were injured by flying chunks of concrete and debris. Three minutes later a fireball arose almost to the high ceiling and a second explosion shook the entire area. Fire continued to burn in a crater 50 feet wide where the seats had been. The building lights stayed on and the band continued to play. There was no panic and most uninjured spectators made their way from the building in stunned silence.

### Casualty List

Briefly, the picture was this: The total casualty list was 436. Fifty-five were dead at the scene of the accident and 19 more died subsequently (total 74). One hundred and sixty-four patients were admitted to hospitals and 210 persons were treated as out-patients.

Of the 55 initial deaths at the scene, causes were determined in 26 head injuries, 14 burns, five chest injuries, nine cervical spine fractures and one abdominal crushing.

Study of eight victims who died en route to the hospital was undertaken to determine whether controllable factors contributed to their demise. Five of these sustained crushing head injuries; two received crushing trauma to the chest. The remaining victim had severe abdominal crushing. It appeared that these injuries were such that employment of the usual first-aid skills and equipment would have made little difference in their outcome.

Identification of the dead except for two badly charred victims was concluded by four o'clock the next day. On the following day, the remaining two bodies were identified.

The 19 deaths subsequent to hospitalization included: eight cerebral contusions with hemorrhage; seven hemothoraces; one abdominal ruptured viscus; one 60% burn; and two infections (one gas gangrene and one empyema).

Two other patients required amputation because of infection and one appears permanently paraplegic at the L-5 level.

### The Three "C's" of Preparedness

The intent of this report is to explore the means by which more lives may be saved, less effort wasted, less confusion occur and less pain and heartache result if another disaster should occur.

Better command, communication and coordination must be achieved. Lives will not be saved in future disasters unless every means to improve preparation and perform-

* Prepared by Indiana Committee on Trauma, American College of Surgeons, September, 1964.

ance is explored and utilized.

How did the people of Indianapolis react to this horrible disaster? What can be learned from their experience?

At 11:06 p.m., fire department dispatchers sent four engine companies, two rescue squads, a ladder truck and a district chief to the scene. The nearest unit, Engine Company 28, arrived within two and one-half minutes of the alarm and quickly laid hose lines into the burning explosion area.

At 11:09 p.m., concise reports from two off-duty firemen in the audience started the flow of additional men and equipment to the scene. The estimate of casualties at this time was 125.

The fire department notified Marion County General Hospital. This call dispatched three ambulances with interns, and under pre-arranged plans, 17 private ambulances were also sent to the scene. The hospital utility truck followed with three large disaster boxes and extra amounts of dressing materials and splints.

The police department sent all available units to the scene where they immediately set up emergency routes and controlled the departing spectators, the curious and the growing flood of arriving emergency equipment.

Civil Defense directors were called and began to put their disaster plan into effect. The Red Cross was notified and sent their disaster units immediately.

### First Aid

The first fire units which arrived came upon a scene of utter destruction. People lay on the ice rink; others were trapped under large pieces of concrete and some were perilously close to the fire-filled blast crater. Treatment centers were set up by three rescue squads inside the building. Then began the task of freeing victims from the rubble.

Firemen, later described as "Angels in Black Rubber Coats," lifted the concrete chunks to free many people. Because of the layout of the arena and the location of the blast, the casualties were carried from the Coliseum through a short covered runway to the cattle barn. This area, used at State Fairs for exhibiting cattle, is not the type of place its name implies but a large open area equally as clean and neat as the Coliseum. Ambulances could be driven into several entrances of this cattle barn and it was used as a triage or sorting area.

The injured were carried from the Coliseum to the cattle barn, a distance of about 50 yards, for the most part on 4 x 8 pieces of plywood which had been stored in the Coliseum for the building of bleachers. While heavy, the improvised stretchers could easily be lifted by four persons. The plywood served as excellent stretchers and probably saved many persons from having their injuries compounded on being moved. Ambulances came through the doors of the cattle barn, were filled and then dispatched through the west doors.

Dressings and supplies of the rescue squads were rapidly exhausted but were supplemented by the disaster boxes from General Hospital and large amounts of previously stock-piled supplies of the Red Cross and Civil Defense organizations. These were augmented by material sent in by Eli Lilly Company and soon a surplus of material accumulated because of the extremely rapid evacuation of the wounded from the scene.

Evacuation of the wounded to the hospitals was carried out in an amazingly rapid manner. Some observers stated that there were only eight to ten injured left on the scene within 30 minutes of the blast, these being deeply trapped in the rubble. All of the wounded were in hospitals within less than two hours time.

The first five wounded were picked up by a General Hospital ambulance in front of the Coliseum and taken to Methodist Hospital. A chartered city transit bus parked outside the building was emptied by the police and used to transfer five other persons with minor injuries to Methodist. The transit company sent another bus immediately and readied more but these were not used. Taxicabs waiting for the conclusion of the show were also used and these brought initial victims to the St. Vincent's Hospital.

General Hospital ambulances, private ambulances and private station wagons carried the bulk of the wounded; there was

no shortage of transportation equipment. All agreed that there was little control over this fleet and attempts to distribute the patient load were in vain. Many drivers disobeyed routing instructions, taking their victims to the nearest hospital encountered on the emergency route established by the police. It was this speed of pick-up and transit that led to the inequitable distribution of patients.

The assigning of patients, the dispatching of ambulances and communication with the hospitals were outstanding weaknesses which contributed to the confusion and resulted in the poor utilization of hospital and medical resources.

### Communications

Initial communications at the scene were by fire and police radios. Amateur mobile units of the "Goblin Patrol" began arriving within five minutes of the blast and a communication center was established in the cattle barn within 30 minutes.

A sound and radio truck owned by a local electric contractor was utilized and operated in association with the Red Cross and Civil Defense. It proved to be the primary message center for about two hours until a master center was established in the Fairgrounds Administration Building across from the Coliseum by Civil Defense and the State Police.

Radio and television coverage was prompt and generous but the essential line of communication between the disaster and the hospitals left much to be desired in the immediate emergency period. Insufficient use was made of the police radio and telephone exchanges were quickly jammed. However, the Indiana Bell Telephone Company promptly sent supervisory personnel to the scene. Their first action was to restrict the Fairgrounds' three telephone lines to out-going calls only.

Four additional lines were fed into the Administration Building control center and manned by phone company personnel until the following morning. Extra lines were placed into the various hospitals and automatic overload service was added to the central Red Cross exchange so that thousands of calls were handled through the night. Special television circuits were in operation within three hours of the blast but much congestion was encountered within the immediate post-blast period because newsmen tied up available phone lines.

As the nation became aware of the disaster, long distance phone lines jammed with an estimated 10,000 long distance calls waiting by morning.

Telephone representatives were sent to each hospital and in all cases, the load was well handled by house equipment and operators. Intramural services in the hospitals, though, required the use of runners. An information center, established at Methodist Hospital was manned by volunteer workers who compiled casualty lists. Speed with which these casualty lists was compiled by this center and by the Red Cross organization was indeed remarkable.

Some doctors and nurses were in the audience and many more came to the scene when they learned of the disaster on radio and television. There was no shortage of professional volunteer assistance there and many left after a short time feeling that they could be of more use at the hospitals. Large numbers of nurses, registered and practical, reported to the scene. Many were in uniform and others arrived after the wounded had been evacuated. Some remained to assist in the identification of the dead and others were transported to the hospitals to augment the personnel there.

The chairman of the county medical society and the medical directors of both the Civil Defense and Red Cross chapter were at the scene and were instrumental in directing the sorting activities.

The county coroner arrived shortly after the blast and supervised sorting of the dead and the establishment of a temporary morgue in the Coliseum.

Twenty-one hospitals with a bed capacity of 3,539 participated in the care of the victims. Sixteen hundred special beds were made available on the night of the disaster. However, distribution of patients was poorly carried out and the brunt of the load was carried by the nearby Methodist and St. Vincent's Hospitals. Other hospitals, including the large General Hospital, the

Continued

(One of a series of ads being used in key Hoosier newspapers)

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**BLUE CROSS - BLUE SHIELD**

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.

HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS 9, INDIANA

large Veterans Hospital and the university hospitals were scarcely utilized.

### Critical Analysis

Now, many months after the disaster, the last patient has left the hospital but tragic consequences and memories remain. We recall that major errors, weaknesses and problems existed in ill-defined lines of command, communications and coordination.

The analysis of the cause of the blast was carried on for a long time after this disaster and it was finally decided that propane gas leaking from a faulty tank touched off the explosion. It was established that no such storage of liquid propane gas should have occurred within this or any other public building.

The Coliseum, itself, had been the scene of disaster drills three times in past years, involving the police and fire departments, Civil Defense, the Boy Scouts and other volunteer organizations. All of our hospitals had disaster plans and some had had disaster drills within a month of the Coliseum disaster.

In studying the emergency care and transportation phase of the disaster, the extreme rapidity of rescue and evacuation of the victims must be remembered. Many disaster personnel, despite prompt arrival, found themselves too late to be of any assistance at the scene. By the time the deficiencies in sorting, communications and patient distribution could be corrected, the job was done and the patient was in the hospital.

The hospital emergency rooms carried out their disaster plans of intramural nature in a remarkable manner and all hospitals were operating on regular schedules by eight o'clock the following morning. Although the handling of the dead received praise from all quarters, the coroner pointed up several shortcomings. Personal effects should have been kept with the bodies under guard to aid in identification and body tags should have been attached directly to the body and not to the clothing. Identification of the dead should have been made by only a few relatives and it was felt that the clergy could have been of greater help in this regard.

Communications were poor. Actual hospital notification of the disaster occurred in a haphazard manner. St. Vincent's Hospital was informed by the incoming injured. Methodist Hospital was called by a staff physician who heard the news on TV. General Hospital was notified by the fire department and a single operator was burdened with the duty of alerting 17 private ambulances in addition to those at General Hospital. No attempt was made to call doctors to needed places nor was any attempt made to assess the capacity of the various hospitals and the availability of the facilities until late in the evacuation stage. Plans had been discussed to send police to the receiving wards to act as message centers but this was not carried out.

### Good Out of Bad

Plans have now been completed for a Red Cross radio network linking the hospitals with the Red Cross Chapter House, and the Civil Defense Headquarters. A backup system by the Amateur Radio Club has also been organized. The telephone company will also make available conference lines to essential stations within a matter of minutes.

The principal problem seems to have been lack of central authority. Rescue work was and should be done by the fire department as this is probably the most suitable organization for it. Overall command should probably be by a police official. With central command lacking, there was little control over the volunteer response of equipment and manpower. This led to an actual clogging of the disaster area by man and vehicle. Without authority and discipline, the sorting was relatively ineffectual. Probably the one phase which failed most and which most threatened the success of the entire program was the inequitable distribution of the victims to the hospitals. There was no medical command post and only belatedly, a general command post was established by the State Police and Civil Defense. Cooperation seems to have been the rule throughout, but coordination of all vital

services did not go according to plan.

Heavy machinery was needed to remove cement, twisted girders and debris from some of the bodies and apparently no previous thought had been given to this need. A crane and bulldozers were brought to the scene of the accident within an hour of the blast together with trained personnel to use them.

This emphasizes the need to catalog in advance every individual, organization and piece of apparatus which might be useful in a disaster. Addresses and telephone numbers, both day and night, of organizations and individuals are now being listed. If useful apparatus is not present in the community, the nearest available location is noted in the inventory.

A registry of essential personnel and equipment in Indiana is being made available through the State Board of Health regional offices and in the State Police Command Posts. Disaster rosters of essential personnel are being developed through the medical societies and Civil Defense organizations.

A survey of 629 emergency vehicles in the state has been completed and card indices have been established in the State Board of Health and State Police offices.

An Institute for Emergency Aid and Transportation of the Injured was held in May, 1964, in Indianapolis and enrolled 99 police, fire and ambulance personnel from all over the state.

A statewide survey of 115 hospital emergency rooms was completed this fall by the Committee on Trauma of the American College of Surgeons.

An improving and responsible relationship between military, Civil Defense and medical leadership is developing through the work of physicians and surgeons serving in all three endeavors.

Activity by the Committee on Trauma of the College of Surgeons continues through its central committee and 24 local committees in the state plus an advisory council of interested governmental and voluntary agency directors.

The Indiana State Board of Health continues to be active in the entire field of trauma and has established both a Poison Control Center and a Radiation Hazard Task Force. Cooperation with the American College of Surgeons, the National Safety Council and the American Red Cross has been noteworthy.

There have been many meetings by many organizations and governmental services concerning this disaster. Although the consensus is that the great number of injured were handled in a magnificent manner by all services, it is also recognized that many shortcomings were found. Honest and continuing efforts are being made to correct these shortcomings and adequate cooperative community programs are developing in our city and state.

**Contributors**

Harry Becker, M.D.—Disaster Committee, Indiana A.C.S.

William Brennan—Ambulance Survey, Indiana A.C.S.

Charles Broderick—Director of Civil Defense, Indianapolis, Indiana

Joseph Finneran, M.D.—Chief of Surgery, St. Vincent's Hospital, Indianapolis, Indiana

Alva Funk—Executive Officer to the Sheriff of Marion County, Indianapolis, Indiana

Robert Kennedy, M.D.—American College of Surgeons (Trauma)

Carl D. Martz, M.D.—Committee on Trauma, Indiana A.C.S., Indianapolis, Indiana

Henry Nester, M.D.—Commissioner of Public Health, Marion County, Indianapolis, Indiana

Jesse Nicholas, M.D.—Coroner, Marion County, Indianapolis, Indiana

William Norman, M.D.—Committee on Trauma, Indiana A.C.S.

Virgil Sheppard—American Red Cross, Indianapolis, Indiana

John Suelzer, M.D.—Transportation Committee, Indiana A.C.S.

John Thompson, M.D.—Emergency Committee, Indiana A.C.S.

Robert Yoho—Indiana State Board of Health, Indianapolis, Indiana ◄

# Report on Actions of the House of Delegates American Medical Association

*18th Clinical Convention*
*November 29-December 2, 1964*
*Miami Beach, Florida*

MIAMI BEACH, Dec. 2—The Indiana State Medical Association was complimented highly for the dignified campaign it staged for the election of Dr. Donald Wood to the position of president-elect of the American Medical Association.

Campaigning got "hot and heavy" the night before the election and a 19 vote switch resulted in Dr. James Z. Appel, Lancaster, Pa., being named president-elect. Dr. Wood remains as a member of the AMA board of AMPAC and on the Council on Legislative Activities of the AMA.

Dr. Wood was introduced to the AMA delegates at a breakfast on Tuesday morning. Approximately 300 delegates and officers of the AMA were present. Dr. Elvis J. Stahr, president of Indiana University, spoke on the "Development of Medical Education." Entertainment was provided by talent from the Indiana University School of Medicine at both the breakfast and in the Indiana hospitality room.

The full delegation from Indiana, including the officers of the association, were present at the AMA meeting.

Resolution No. 2, presented at the October annual ISMA meeting by the Vanderburgh County Medical Society, was presented by the Indiana delegation at the Miami meeting. The resolution called for the development of a reasonable and fair program to insure equitable protection of all those whose interests are involved and to insure that the medical profession will retain greater control and influence in the handling of drug therapy.

The resolution was referred to the Reference Committee on Miscellaneous Business. Their report, which was adopted, is as follows:

"*Resolution 9 - Control of Drug Therapy.* Your reference committee reviewed progress, to date, in implementing the recommendations of Resolution 9. Your reference committee has been informed that the objectives of this resolution are being achieved by the Council on Drugs as rapidly and effectively as available time and personnel will permit. A suitable program to provide proper protection for the public with appropriate leadership from the profession has been formulated and is being carried out.

Mr. Speaker, I move that no action be taken by the House of Delegates on Resolution 9."

Indiana will have another election campaign at the June AMA meeting in New York. Dr. Lester D. Bibler, Indianapolis, member of the AMA Board of Trustees, will be up for re-election to a three-year term. Dr. Bibler was elected to the board two years ago when the Board of Trustees was enlarged.

Health care for the aging, a new teletype communications system for the medical profession, a statement on human reproduction and recommendations from the Commission on the Cost of Medical Care were among the major subjects acted upon by the house.

Tribute was paid to the late Dr. Norman A. Welch, AMA President who died on September 3 in a memorial statement from the Massachusetts Medical Society and in a resolution adopted by the house.

Dr. James Z. Appel of Lancaster, Pa., vice-chairman of the AMA Board of Trustees and a member of the board since 1957, will become president in June, 1965, succeeding Dr. Donovan F. Ward of Dubuque, Iowa, who took office after the death of Dr. Welch.

To take Dr. Appel's place on the AMA Board of Trustees, the house elected Dr. Joseph B. Copeland of Austin, Texas, who

for the past year has been serving as Deputy Commissioner of Health in the State of Texas.

Final registration at the convention reached a total of 9,356, including 4,118 physicians.

### Health Care for the Aging

Definitive action on the issue of health care for the aging came with the House of Delegate's strong endorsement of Dr. Ward's Monday address, in which he declared that "We have no choice except to stand firm in our efforts to prevent the standards of health care in this country from being undermined by a radical departure from the unique American way which has accomplished so much for mankind."

Reaffirming the association's opposition to the King-Anderson type of legislation, Dr. Ward said:

"If we have been right in the past—and that is our unshakeable belief—then we are right today. And we shall be right tomorrow."

Calling for renewed, intensive effort to prevent the passage of such legislation, he pointed out that "we do not, by profession, compromise in matters of life and death. Nor can we compromise with honor and duty."

Dr. Ward, expressing pride in the medical profession, concluded his address with these statements:

"I pray that we all gain strength for renewed effort by the simple reflection that what we are doing is worthwhile—that if the effort is great, the results of not making the effort would be unthinkable—and, finally, what we are doing is vastly more important than ourselves.

"No more can be asked of us as citizens. No less should be offered by us in guarding our heritage of freedom."

To implement the ideas in Dr. Ward's address, the house gave unequivocal approval of a Board of Trustees' suggestion that an expanded educational program be conducted in the next few months. In asking for this approval, the board pointed out that "a variety of technics and media must be utilized if the public, the Congress and special audiences are to be reached effectively."

The house took no action on three resolutions which would have altered the AMA position on health care legislation. Instead, the house adopted a resolution which urged "component associations to stimulate the state and local governments to seek the fullest possible implementation of existing mechanisms, including the voluntary health insurance principle, to the end that everyone in need, regardless of age, is assured that necessary health care will be available."

The state medical societies also were urged to send representatives to two forthcoming conferences related to the issue of health care for the aging—one on December 13 to help plan the new educational program and the other on January 9-10, 1965, to consider further implementation and expansion of the Kerr-Mills programs.

### Teletype Communications System

The house approved a recommendation from the Board of Trustees for establishment of a tele-typewriter communications service between the AMA and the state medical societies. The system will provide automatic and uninterrupted communications between AMA headquarters and all participating state societies and between the state societies without involving the facilities at the AMA headquarters. The system also will enable any state society to communicate with all other TWX subscribers in the United States and Canada.

In approving the recommendation, the house emphasized that participation is optional with the state medical societies but it also urged each society to "seriously consider taking advantage of this rapid communications system." Installation and rental costs for the teletype equipment, both at AMA headquarters and at the headquarters of each participating medical society, will be paid by the AMA. The cost of transmitting messages will be paid by whichever organization originates the message. It is hoped that the new communications system will become operative no later than July, 1965.

Continued on page 72

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1. Kunin, C. M. et al.: J. Clin. Invest. 38:1950, Nov., 1959.

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### Human Reproduction

Updating its policies on population control, "to conform to changes in society and medicine" and to "take a more positive position on this very important medical-socio-economic problem," the house adopted the following four-point statement:

"1. An intelligent recognition of the problems that relate to human reproduction, including the need for population control, is more than a matter of responsible parenthood; it a matter of responsible medical practice.

"2. The medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family.

"3. In discharging this responsibility, physicians must be prepared to provide counsel and guidance when the needs of their patients require it or refer the patients to appropriate persons.

"4. The AMA shall take the responsibility for disseminating information to physicians on all phases of human reproduction, including sexual behavior, by whatever means are appropriate."

In taking the action, the house also recommended that the AMA cooperate with the appropriate voluntary organizations in the field of human reproduction which have adequate medical direction.

### Commission on the Cost of Medical Care

With modifications suggested by the Board of Trustees, the house approved 33 recommendations from the Commission on the Cost of Medical Care. The suggestions had been rearranged by the board into four sections — research, hospitals, physicians and miscellaneous. In accepting the board report, the house also rejected a floor amendment which recommended that a medical advisory committee composed of practicing physicians be appointed to supervise the several studies which were suggested.

In presenting its conclusions and recommendations to the Board of Trustees, the Commission on the Cost of Medical Care expressed the hope "that the recommendations which are approved will help promote the wisest possible use of the medical care dollar and aid in the development of more meaningful data on the cost of medical care."

The house learned that a substantial number of the studies recommended by the commission are already under way and that others are in the process of being implemented. The house also emphasized its appreciation of the importance of these continuing studies and urged that adequate funds be provided for maximum implementation of the recommendations.

### Miscellaneous Actions

In considering a wide variety of annual reports, special and supplementary reports and resolutions, the house also:

Amended the Bylaws to permit the presidential inauguration to take place at a time other than Tuesday evening and approved a suggestion that the inaugural ceremony at the 1965 Annual Convention be held on Sunday, June 20;

Amended the Bylaws to permit presentation of the AMA Distinguished Service Award at a time to be determined by the Board of Trustees and learned that the board wishes to present this award at the Scientific Awards Dinner;

Agreed that the AMA should cooperate with the U.S. Public Health Service in eradicating the Aedes aegypti mosquito from the American hemisphere;

Urged strong support of the woman's auxiliary and asked the state and county medical societies to give serious consideration to the idea of joint husband-wife memberships;

Agreed that a section on Space Medicine should not be created at this time;

Emphasized its continuing awareness of the demand for action on satisfying the need for increasing numbers of family physicians;

Urged all state and component medical associations to approve, where feasible, the inclusion of a voluntary, nondeductible contribution to independent political action committees on the society's annual dues billing statement;

Approved a board recommendation that

the 1967 Clinical Convention be held in Houston, Texas;

Agreed with the board that there should not be an increase in AMA dues at this time;

Reaffirmed its approval and support of the National Council for Accreditation of Nursing Homes and

Instructed the board to re-evaluate the mission of the Commission on Medical Practice and take appropriate action.

The American Medical Association Education and Research Foundation reported to the house that one out of every six medical students, interns and residents in the U.S. is now receiving financial assistance from the foundation's loan fund. The AMERF also announced that Merck Sharp & Dohme pharmaceutical company has made its fourth $100,000 contribution to the loan fund and has pledged an additional $100,000 in 1966. ◄

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# Kerr-Mills Law Goes into Effect in Indiana; Welfare Department Lists Rules, Regulations

**Regulation 2-601** *Medical Assistance for the Aged—Effective Date*

Medical assistance for the aged shall be administered by the county departments of public welfare under the supervision of the state department of public welfare. The program shall be administered in accordance with the requirements of Title I of the Social Security Act and the Indiana Plan for Old Age Assistance and Medical Assistance for the Aged as set forth in Part III of The Welfare Act of 1936, as amended, and Chapter 432, Acts of 1963.

The effective date of medical assistance for the aged shall be January 1, 1965, or on the date that the medical assistance for the aged plan is approved by the Department of Health, Education and Welfare, whichever is the later of the two dates.

Sec. 2, Ch. 432, Acts 1963
Sec. 22, Ch. 432, Acts 1963

Adopted October 28, 1964

**Regulation 2-602** *Application—Medical Assistance for the Aged*

Application for medical assistance for the aged shall be made to the county department of public welfare of the county in which the applicant has established a bona fide residence.

Sec. 2(1), Ch. 432, Acts 1963
Sec. 3(3), Ch. 432, Acts 1963
Sec. 4, Ch. 432, Acts 1963
1964 O.A.G. No. 29

Adopted October 28, 1964

**Regulation 2-603** *Emergencies—Medical Assistance for the Aged*

If an applicant is in need of medical care and is unable to sign an application under his oath because of a mental or physical disability, a statement describing the applicant and his condition as given by a person representing the applicant may be accepted in lieu of the signed application. This statement shall be considered as the necessary authority to proceed with the determination of eligibility and shall also serve to establish the effective date for the payment of medical or remedial care.

Such a statement shall not be considered as a formal application and an award of medical assistance shall not be approved until an application has been signed by the applicant or his legally appointed guardian. However, if the applicant remains mentally or physically unable to sign the formal application and a guardian has not been appointed for a period of ninety days following the acceptance of the statement, or if the applicant dies before he became mentally or physically able, or before a guardian was appointed to sign the application under oath, such statement shall be used as the basis for the approval of an award of medical assistance for the aged, providing the applicant is determined to be otherwise eligible.

If an application has been signed under oath of the applicant or his legally appointed guardian and the applicant dies before the county board has considered the application, the award of medical assistance for the aged shall be approved following his death providing the applicant is determined to be otherwise eligible.

Sec. 2(1), Ch. 432, Acts 1963
Sec. 2(3), Ch. 432, Acts 1963
Sec. 2(4), Ch. 432, Acts 1963
Sec. 4, Ch. 432, Acts 1963
Sec. 22, Ch. 432, Acts 1963
1964 O.A.G. No. 60

Adopted October 28, 1964

**Regulation 2-604** *Recipients Who Move to Another County in Indiana—Medical Assistance for the Aged*

When a recipient of medical assistance for the aged abandons his residence in the county from which he is receiving assistance and establishes a bona fide living arrangement in another county, the county department of the county to which he has moved shall accept an application, complete the investigation and award assistance within ninety days from the date the new

residence was established, so long as he remains otherwise eligible.

Payment of claims for medical services shall be the responsibility of the county from which recipient has moved until such time as the county to which recipient has moved has established an effective date for the assistance award.

When an applicant for or a recipient of medical assistance for the aged leaves a county in which there are insufficient licensed facilities, or the attending physician certifies the need for the services of a licensed facility located in another county, the removal of the recipient to such county for such reasons shall not constitute the abandonment of residence and the county from which he has moved shall continue to be responsible for the payment of medical care and services.

Sec. 2(1), Ch. 432, Acts 1963
Sec. 2(3), Ch. 432, Acts 1963
Sec. 4, Ch. 432, Acts 1963
1964 O.A.G. No. 29

Adopted October 28, 1964

**Regulation 2-605** *Personal Property—Medical Assistance for the Aged*

(a) An applicant for or a recipient of medical assistance for the aged may have personal property with the net value of no more than $2,500, of which no more than $500 shall be in cash or maturity value of stocks and bonds if the applicant or recipient is unmarried or not living with a spouse, nor more than $1,000 if the applicant or recipient is married and living with a spouse.

(b) An automobile shall be considered as personal property and its value shall be included in the total net value of personal property. In the determination of the value of an automobile, the market value, or the amount of money required to replace it in its present condition, shall be used.

The net value of personal property shall not include life insurance, household goods, wearing apparel, or personal effects.

For the purposes of medical assistance for the aged, personal effects are defined as possessions of an individual which may be worn or carried and which have a more or less intimate relation to the individual. A possession which has been inherited and considered an heirloom may be classified as a personal effect, as wearing apparel or as household goods. If such a classification cannot be made, it shall be considered in the same manner as other personal property.

(d) Personal property essential to usual employment from which income is derived shall not be considered in determining the net value of personal property an applicant or recipient may have.

Sec. 2(3), Ch. 432, Acts 1963
Sec. 2(5), Ch. 432, Acts 1963
1964 O.A.G. No. 29

Adopted October 28, 1964

**Regulation 2-606** *Effective Dates and Payment of Medical Assistance for the Aged*

(a) The effective date of awards for medical assistance for the aged approved by the county board of public welfare shall be the first day of the month in which an application or a statement from the applicant's representative describing his condition was accepted, or the date of the applicant's 65th birthday if it is later than the first day of the month in which the application or statement was accepted.

(b) The effective date of continuances, denials, and discontinuances shall be the first day of the month following county board action, except the effective date of a discontinuance because of the death of a recipient shall be the first of the month following the date of death.

(c) Payment of claims for medical or remedial care shall be made the first of the month following county board approval directly to the person, corporation, association, institution or agency furnishing the services in accordance with the county department's medical plan.

Sec. 1(g), Ch. 432, Acts 1963
Sec. 2(3), Ch. 432, Acts 1963
Sec. 7, Ch. 432, Acts 1963
Sec. 22, Ch. 432, Acts 1963

Adopted October 28, 1964

**Regulation 2-607** *Reinvestigations—Medical Assistance for the Aged*

The county department of public welfare shall reinvestigate medical assistance for the aged cases at least every twelve months or more frequently if required by changing

circumstances. The reinvestigation shall include but not be limited to at least one interview with the recipient or his representative; a complete recording of such conditions as are subject to change; and official action by the county board of public welfare.

Sec. 2(3), Ch. 432, Acts 1963
Sec. 2(4), Ch. 432, Acts 1963
Sec. 22, Ch. 432, Acts 1963
Adopted October 28, 1964 ◄


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*Medicine At Law*

# DECISIONS AND OPINIONS

**Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.**

*Doctor Negligent in Treatment of Fractured Arm—Comment on Patient's Failure to Call Examining Doctor as Witness*—In a malpractice suit against a doctor by a patient who was afflicted with Volkmann's ischemic contracture of his left arm following the doctor's treatment of a supracondylar fracture of the arm, the evidence was sufficient to support the jury's verdict in favor of the patient, the Oklahoma Supreme Court ruled.

The patient fractured his arm when he was two years old. The malpractice suit was not filed until approximately 20 years later.

The patient presented medical testimony tending to establish that the Volkmann's contracture was caused by the impairment of circulation in his arm due to improper bandaging and lack of after-care by the doctor and that this condition occurred within 48 hours after the arm was fractured. Accepted medical practices recognized that such contracture had to be guarded against, and the maintenance of adequate circulation was of greater importance than satisfactory reduction of the fracture. There was testimony that the patient's hand was badly swollen and that the doctor split the bandage and treated local gangrene which developed within 48 hours after the fracture had been reduced but did not change the arm from the "Jones position" in which it had been placed at the time of the reduction of the fracture.

The doctor presented evidence that Volkmann's contracture can be caused in various ways and cannot always be avoided despite the degree of care exercised. An orthopedic surgeon who had examined the patient's medical records and x-rays testified that the doctor's treatment had nothing to do with the patient's disability which, in his opinion, resulted from the injury alone.

The evidence as to the cause of the patient's condition was conflicting and, in determining whether the doctor's treatment was ordinarily skillful and proper, the jury was not required to accept the testimony of the doctor's expert witnesses. The jury's determination that the doctor failed to treat the patient in an ordinarily skillful, careful, and diligent manner was supported by competent evidence, the court said.

A doctor who examined the patient prior to the trial, preparatory to testifying in his behalf, was not called as a witness by the patient. (In a post-trial affidavit he stated that he became reluctant to testify when he learned that the doctor being sued had no insurance.) In his closing argument to the jury, the doctor's attorney stated that, since the doctor who had examined the patient prior to trial had not been called by the patient as a witness, the only logical conclusion was that the examining doctor's testimony would have been unfavorable. The patient's attorney, in his closing argument to the jury, stated that the examining doctor had said that he "agreed this was the grossest case of malpractice he had ever seen in his life." The remark of the patient's attorney was improper, but it had been "invited" by the argument of the doctor's attorney and was not reversible error, in the absence of a showing that the verdict was "quite plainly" influenced by the remark of the patient's attorney, the court said.

*Sisler v. Whitten*, 393 P. 2d 497 (Okla.,

March 24, 1964; rehearing denied, May 27, 1964; application for leave to file second petition for rehearing denied, June 30, 1964).

*Furnishing of Blood for Transfusion not a Sale*—A patient who developed serum hepatitis after a blood transfusion administered in the course of an operation was not entitled to recover damages in a suit against the hospital which furnished the blood, based on the hospital's alleged breach of an implied warranty that the blood was fit for the purpose for which it was furnished, a federal trial court ruled.

The hospital's furnishing of the blood was completely subordinate to its primary function of providing trained personnel and specialized facilities for the purpose of restoring the patient's health. The essence of the hospital-patient relationship is that the hospital undertakes to make human skill and physical material available to the patient in an effort to restore his health. The contract between the hospital and the patient was clearly one for services and was not divisible. Although title to blood may be transferred when it is furnished for a transfusion, that does not make the transaction a sale. Nor does payment for the blood, even as a separate item on the bill, make the transaction a sale, the court said. The furnishing of the blood was merely incidental to the hospital's rendition of services. Since the transaction was not a sale, it could not give rise to a cause of action for breach of an implied warranty.

*Sloneker v. St. Joseph's Hospital,* Civil Action No. 8615 (D.C., Colo., Aug. 24, 1964).

*Treating Doctor's Testimony Insufficient to Establish Disability*—Although a doctor's testimony that a claimant for Workmen's Compensation benefits was permanently disabled as the result of having been struck on the foot and ankle by a steel beam, was entitled to considerable weight, because of his training in orthopedics and his position as the treating doctor, it was not sufficient to establish that the claimant was disabled, a Louisiana intermediate appellate court ruled. Three orthopedic surgeons who examined the claimant testified that they found no disability. The expert testimony clearly preponderated against any injury to the claimant other than a contusion of his ankle, the court said.

*Dubois v. Travelers Insurance Company,* 160 So. 2d 821 (La., Feb. 18, 1964).

*Proceeds of Sale of Professional Practice May be Taxable as Capital Gain*—The Internal Revenue Service has ruled that the sale of a professional practice can, in some instances, result in a capital gain. The service had previously taken the position that no portion of the sale price of a professional practice or other one-man business which depended solely on the professional skill or other personal characteristics of the seller for its success could be treated as proceeds from the sale of good will and taxable as a capital gain. In the future, in determining the extent to which the proceeds of the sale of an entire professional practice can be allocated to a sale of good will, the Service will consider the facts of the particular case.

However, where a professional person merely admits partners, instead of selling his entire practice, no part of the proceeds will be regarded as payment for good will; and the proceeds of the sale will be taxable as ordinary income. The Service takes the position that, by admitting partners, the professional person is relinquishing his right to part of the practice's future earnings, but that he would continue to enjoy the benefit of any good will that he might have built up.

*Rev. Rul.* 64-236, I.R.B. 1964-35, 11 (Aug. 31, 1964). ◄


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# Changes in Blue Shield Payment Patterns

*(One of a series prepared by Blue Cross-Blue Shield)*

Year after year our sales efforts continue to stress the importance of adequate Blue Shield protection, and emphasis is placed on selling the preferred surgical and anesthesia schedules, preferred in-hospital medical protection and diagnostic x-ray and pathology endorsements. Every effort is made to sell new accounts—and convert old accounts—to these benefits.

The table below graphically indicates what the success of this sales effort has done to the Blue Shield payment pattern analyzed in terms of medical classifications. For example, anesthesia and diagnostic benefits were not available in 1949. In 1963, anesthesia payments totaled $1,793,533.42 and diagnostic payments reached $1,783,-889.73. Payments for in-hospital medical services jumped from $8,411.00 in 1949 to $4,127,277.06 in 1963. Significant increases also occurred in payments for "all other surgical" and "radiation therapy."

Medical practice has undergone many changes since 1949, and Blue Shield continues to keep up with medical practice today.

| | AMOUNT PAID | | |
|---|---|---|---|
| Medical Classification | 1949 | 1963 | 1963 over 1949 |
| **SURGICAL:** | | | |
| T & A | $144,955.00 | $621,107.40 | 4.3% |
| Eye, Ear, Nose and Throat | 72,388.00 | 1,414,957.00 | 19.5 |
| Appendectomy | 205,840.00 | 385,949.62 | 1.9 |
| Hernia | 42,690.00 | 745,680.75 | 17.5 |
| Abdominal | 91,910.00 | 1,310,813.08 | 14.3 |
| Proctology & Urology | 109,518.50 | 1,660,089.38 | 15.2 |
| Orthopedics | 114,395.50 | 2,118,434.67 | 18.5 |
| Radiation Therapy | 9,786.00 | 259,168.00 | 26.5 |
| All other surgical | 110,903.50 | 2,960,286.95 | 26.7 |
| Total Surgical | $902,386.50 | $11,476,486.85 | 12.7 |
| **MEDICAL:** | $8,411.00 | $4,127,277.06 | 409.7 |
| **MATERNITY:** | | | |
| Deliveries | $259,764.00 | $1,922,084.00 | 7.4 |
| Gynecology | 261,854.50 | 1,575,636.93 | 6.0 |
| Total Maternity | $521,618.50 | $3,497,720.93 | 6.7 |
| **ANESTHESIA:** | * | $1,793,533.42 | |
| **DIAGNOSTIC:** | * | $1,783,889.73 | |
| Grand Total | $1,432,416.00 | $22,678,907.99 | 15.8 |

* These benefits were not available in 1949.

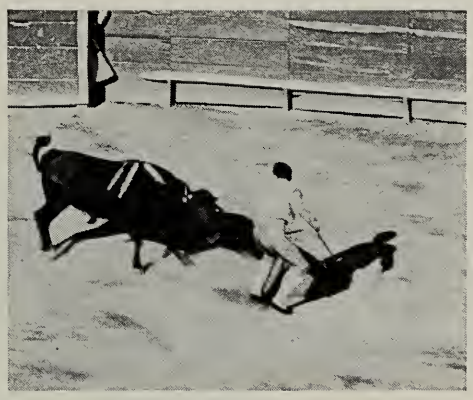
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Before prescribing, see SK&F Product Prescribing Information.

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# Annual Meeting Dates of Professional Medical and Allied Organizations

**AMERICAN MEDICAL ASSOCIATION CONVENTION**
Date June 20-24, 1965
Place New York, N. Y.

**AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER**
Date May 2-5, 1965
Place Aboard the Delta Queen Riverboat, leaving from Cincinnati, O.

**BONE AND JOINT CLUB**
Date April 14, 1965
Place The Athenaeum, Indianapolis

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date March 9-11, 1965
Place Murat Temple, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 19, 1965
Place Indianapolis

**INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS**
Date May 15, 1965
Place Indianapolis Athletic Club

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 13-15, 1965
Place Murat Temple, Indianapolis

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

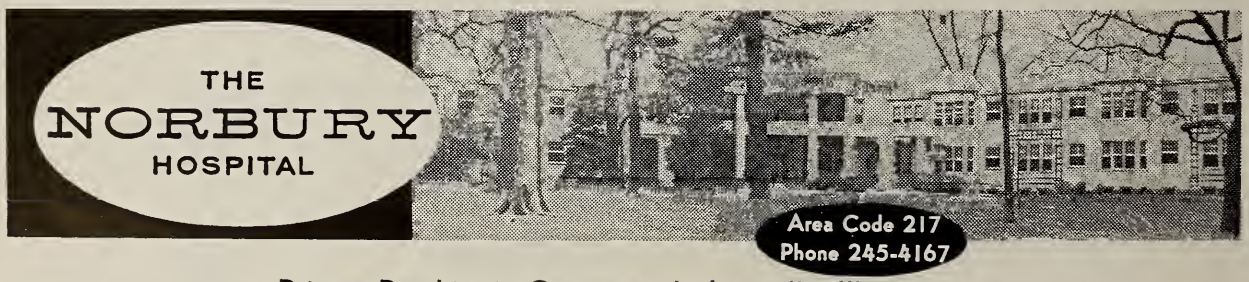
**INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**
Date May 7-8, 1965
Place Oakbrook, Ill.

**INDIANA ORTHOPAEDIC SOCIETY**
Date June 25-26, 1965
Place Marott Hotel, Indianapolis

**INDIANA CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS**
Date April 21-22, 1965
Place Marott Hotel, Indianapolis

**INDIANA ROENTGEN SOCIETY**
Date May, 1965
Place Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

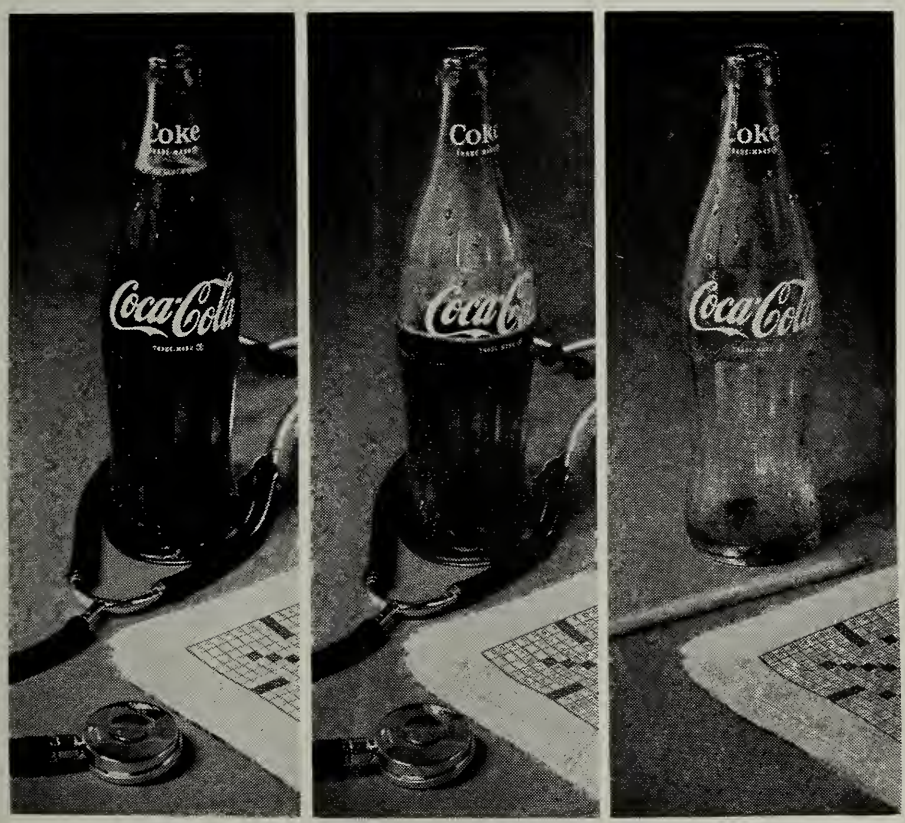
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# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT — November, 1964

| Disease | Nov. 1964 | Oct. 1964 | Sept. 1964 | Nov. 1963 | Nov. 1962 |
|---|---|---|---|---|---|
| Animal Bites | 603 | 896 | 799 | 649 | 526 |
| Chickenpox | 404 | 205 | 26 | 385 | 367 |
| Conjunctivitis | 77 | 124 | 96 | 75 | 85 |
| Diphtheria | 0 | 0 | 0 | 4 | 0 |
| Dysentery, Unspecified | 28 | 237 | 47 | 56 | 46 |
| Gonorrhea | 299 | 262 | 361 | 279 | Not Available |
| Impetigo | 95 | 198 | 184 | 169 | 151 |
| Infectious Hepatitis | 28 | 43 | 35 | 69 | 55 |
| Infectious Mononucleosis | 52 | 47 | 32 | 38 | 20 |
| Influenza | 665 | 911 | 299 | 566 | 1351 |
| Measles (Rubeola-Rubella) | 130 | 158 | 96 | 299 | 140 |
| Meningitis, Meningococcal | 5 | 4 | 5 | 2 | 2 |
| Meningitis, Other | 9 | 8 | 11 | 6 | 10 |
| Mumps | 287 | 173 | 96 | 235 | 188 |
| Pertussis | 22 | 50 | 40 | 27 | 72 |
| Pneumonia | 238 | 242 | 152 | 131 | 148 |
| Poliomyelitis | 1 | 2 | 4 | 0 | 4 |
| Streptococcal Infection | 426 | 497 | 395 | 386 | 321 |
| Syphilis | | | | | |
| Primary & Secondary | 9 | 9 | 6 | 5 | Not Available |
| All Other Syphilis | 101 | 118 | 94 | 120 | Not Available |
| Tinea Capitis | 11 | 47 | 4 | 14 | 12 |
| Tuberculosis (Active) | 87 | 120 | 89 | 98 | 110 |


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## ABSTRACTS

## BOOK REVIEWS

### THE TRANSFER OF CALCIUM AND STRONTIUM ACROSS BIOLOGICAL MEMBRANES

Proceedings of a conference held at Cornell University, Ithica, N.Y., edited by R. H. Wasserman; Academic Press, New York, N.Y.; 43 pages; $11.50.

The frontiers of medicine are expanding constantly; biochemistry and physics are being invoked more and more to explain the basic truths being discovered, analyzed and then integrated into the warp and woof of macromolecular medicine.

The cations are absolutely essential for the working of all known membranes. The interplay of sodium and potassium has been studied longer and is somewhat better understood. Calcium, magnesium and strontium are just being explored; their interplay is understood but poorly. Calcium is just about ubiquitous in its bindings within connective tissues. No muscle can twitch without calcium being present. Such hormones as vitamin D and parathyroid products mediate calcium transfer through cell membranes. Serotonin, acetylcholine and such will cause the intact muscle cell to contract; actomyosin will not respond in the absence of calcium. What are these complex, indirect mechanisms?

The discussion of these problems leads one into tough dilemmas that cause frustration in our groping for the nuggets of truth. This symposium is not easy reading. It can be recommended for the student having the patience and basic background to plod along with the participants of the symposium. As we begin to understand these phenomena, we begin to understand how to control events. Strontium 90 will hold fewer terrors: at least, we know what to expect.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

### IMMUNOASSAY OF HORMONES

Edited for the Ciba Foundation by G. E. W. Wolstenholme and M. P. Cameron; Little, Brown and Co., Boston, Mass., 1962; 419 pages with numerous figures and tables; $10.75.

We would not have had the amazing progress that is being made in the field of immunology and endocrinology had we not had frequent gatherings of the leaders in these fields. The experts exchange experiences and give each other ideas: that makes for progress.

In this colloquium, 28 authorities review the growth hormone, insulin, glucagon, thyrotropin, corticotropin prolactin and the gonadotropins. Areas of ignorance and disagreement stand out


in the overweight stable adult

...fasting serum levels of insulin are usually normal, postprandial levels excessive[1-3]

...insulin acts in adipose tissue via hexose monophosphate shunt, principal path of glucose conversion to storage fat[1,4]

...excessive endogenous insulin acts to stimulate lipogenesis and weight gain[1,3,4]



in vivid relief. A consensus is reached on many matters that will appear in the next editions of standard textbooks.

The printing and binding are splendid; typographical errors are conspicuous by their absence. This is tough reading for all but the expert. To be recommended for hospital libraries, research workers and the really eager beavers who want to be right up there with the latest—until the doctrine of today becomes the error of tomorrow.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

## CELLULAR INJURY

Ciba Foundation Symposium, edited by A. V. S. de Reuck and Julie Knight; Little, Brown and Co., Boston, Mass., 1964; 406 pages with numerous illustrations and tables; $12.00.

This very excellent symposium is the report of a meeting held in the middle of 1963. It should be read after reading the essence of the symposium held on *Lysosomes*.

As usual, this book is not light fare; however, there is much that is thought-provoking. Why does $Ca^{++}$ have to be removed from the cell membrane before a leucidin-poisoned cell can leak out its $K^{+}$ and $Mg^{++}$? Why do omental vessels continue to leak fluid in response to irritation long after the rest of the peritoneal serosa has stopped doing so? Why do steroids protect cells in one situation and cause cell death in another? Just how does $Ca^{++}$ inhibit ATP within the cell? Is this part of the irreversible changes occurring within a myocardial infarct? Then—where does the cell protecting action of the digitalis compounds come in??

This book is another step on the long path leading to further clarification of the basis of macromolecular medicine. Not easy but rewarding to the serious student.

As usual in this series, the binding is good, the format excellent and the editing meticulous.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

## SYNOPSIS OF PATHOLOGY

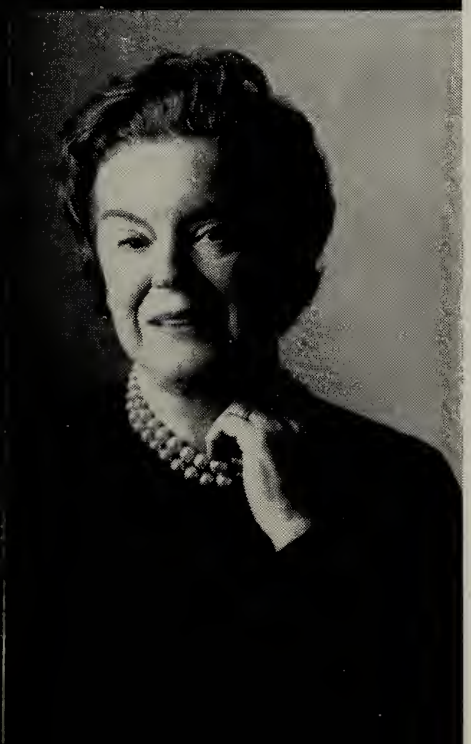
W. A. D. Anderson, 833pp., 6th edition, 406 illustrations, $9.75. C. V. Mosby Co., 3207 Washington Blvd., St. Louis 3, 1964.

Anderson's *Synopsis of Pathology* is designed to serve as a compact, concise, yet comprehensive source of human pathology. It achieves its purpose through the liberal use of clear, well chosen illustrations and tables and a critically edited text. Basic pathological processes, such as the inflammatory reaction and metabolic disturbances, are included as well as infectious conditions, parasitic diseases and the pathology of the various systems. The book is well indexed, making it easy to find the subject matter.

Continued


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...DBI lowers high blood sugars without promoting fat synthesis, encourages gradual weight loss[2-9]



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DBI promotes glucose utilization via the physiologic Embden-Meyerhof pathway... reduces high blood sugars, lowers toward normal elevated blood insulin levels, encourages gradual weight reduction. For the ketoacidosis-prone diabetic, however, insulin is still the essential hypoglycemic agent.

**side effects:** Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in non-diabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B.U.N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **pregnancy warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.* Consult product brochure for full information.

1. Gordon, E.S.: Metabolism 11:819, 1962. 2. Grodsky, G.M. et al.: Metabolism 12:278, 1963. 3. Weller, C. et al.: Scientific Exhibit, A.M.A., June 1962. 4. Sadow, H.S.: Metabolism 12:333, 1963. 5. Faludi, G.: J. Am. Med. Women's Assoc. 18:722, 1963. 6. Faludi, G.: Geriatrics 18:452, 1963. 7. Williams, R.H.: Textbook of Endocrinology, Ed. 3, Saunders, Phila., 1962, p. 610. 8. Weller, C. and Linder, M.: Am. Therap. Soc., June 1963. 9. Moss, J.M. et al.: Med. Times, July 1964.

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Continued

Dental students, medical students and practitioners in all fields of medicine will find this work a concise, authoritative and current text for ready reference.

JAMES J. SULLIVAN, M.D.
Indianapolis

## Abstracts From Various Literature, Prepared by AMA

### HYPERBARIC CHAMBER AT ROYAL VICTORIA HOSPITAL, MONTREAL

J. H. Duff et al. (Royal Victoria Hosp., Montreal).

*Canad. Med. Assoc. J.* 91:1051 (Nov. 14), 1964.

The single apparent and potential benefit of hyperbaric oxygen is the great increase in dissolved oxygen achieved when breathing pure oxygen at increased pressure. The design of an economical chamber for this purpose is presented. A large number of physiological measurements (cardiac output, EEG, ECG) can be performed on patients or experimental animals within the chamber by use of unique electronic connections in the chamber wall which permits all recording equipment to remain outside. Expected arterial blood oxygen tensions were achieved in patients studied at two, three, and four atmospheres. Safety features are emphasized. No complication has resulted in 113 dives over the period January to June, 1964, in which half were for treatment of patients. The chamber was used clinically as an adjunct to treatment of shock, certain forms of malignancy, aerobic infections, coronary occlusion, problems of ischemia and for preservation of organs for transplantation.

### CLINICAL AND THERAPEUTIC ASPECTS OF KEROSENE POISONING

B. J. Baldachin and R. N. Melmed (Mpilo Central Hosp., Bulawayo, Southern Rhodesia)

*Brit. Med. J.* 2:28 (July 4), 1964.

Two hundred cases of kerosene poisoning seen in a five-year period are reviewed. Clinical and radiological findings showed that the most significant complication was pulmonary damage following aspiration. Systemic effects of kerosene absorption from the alimentary tract appeared to be of little practical importance. All the patients under review were treated conservatively with prophylactic penicillin. Gastric lavage was not used. The low mortality rate of 0.5% (one death), in spite of the fact that almost all the patients were under five years of age, indicated that gastric lavage has no place in treatment and it is suggested that it may increase the danger of aspiration of kerosene by inducing vomiting.


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## FATAL HEMORRHAGIC PANCREATITIS FOLLOWING CHLOROTHIAZIDE ADMINISTRATION IN PREGNANCY

S. Minkowitz et al. (450 Clarkson Ave., Brooklyn)

*Obstet. Gynec.* 24:337 (Sept.), 1964.

Two fatal cases of acute pancreatitis following chlorothiazide administration during pregnancy were observed. This complication was reported previously in nonpregnant patients. Experimental studies in mice suggested a causal relationship between the production of pancreatitis and the administration of chlorothiazide. It is of special interest that relatively small therapeutic doses of the drug occasionally appear to cause the toxic reactions.

## SALK AND SABIN VACCINATION OF POPULATION GROUPS: AN EPIDEMIOLOGIC EVALUATION

L. J. Taubenhaus (11 Pierce St., Brookline, Mass.), R. F. Freckleton, and E. K. Donnellan

*Arch. Environ. Health* 9:37 (July), 1964.

In a study of 3,596 community participants in a Sabin vaccine program, 3,352 (90%) had received previous Salk immunizations. The number of individuals with circulating antibodies to the three types of poliomyelitis viruses was proportional to the quantity of Salk vaccine received, with some variation according to age group. There was a group, however, that showed no circulating poliomyelitis antibodies in spite of the Salk vaccination. Subsequent Sabin vaccination of the total population group resulted in seroconversion of most of the Salk failures as well as in the nonvaccinated.

## REPORT OF TWO SISTERS WITH MYASTHENIA GRAVIS AND HYPERTHYROIDISM

J. Greenberg (General Infirmary, Leeds, England).

*Arch. Neurol.* 11:219 (Aug.), 1964.

Two sisters, each of whom developed myasthenia and hyperthyroidism, are described. The first sister had been on massive doses of neostigmine for 17 years when hyperthyroidism developed. For the first time, she was able to discontinue the neostigmine completely. The treatment of the hyperthyroidism did not seem to exacerbate the myasthenia. The second sister developed symptoms of hyperthyroidism in 1956. In addition, she had diplopia which did not respond to antithyroid treatment. As she became euthyroid, the complete picture of myasthenia gravis evolved. When she developed hypothyroidism from Hashimoto's disease, the myasthenia worsened. When the hypothyroidism was treated, the myasthenia then improved. The literature of familial myasthenia and the genetics of hyperthyroidism are reviewed. The relationship between these two diseases in the same patient is discussed. ◄


## SCIENTIFIC EXHIBIT APPLICATION FORM

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Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 12-14, 1965, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

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State_____

## WANTED: Physicians Locations

### GENERAL PRACTICE

Charles R. Farmer, 2157 Benson, Apt. #24, Dayton, Ohio

Joseph R. Shackelford, 1849 Corrine Dr., Oklahoma City, Okla.

Thomas W. Trussell, Chief Medical Officer, U. S. Penitentiary, Marion, Ill.

Albert T. Willardo, 3814 N. Ruckle, Indianapolis 46205

Filemon P. Lopez, 2600 N. Brinton Ave., Dixon, Ill. 61021

Robert R. Cameron, 5467 West Hirsch, Chicago, Ill. 60651

Rene M. Jacobs, Chicago Medical School, 2020 W. Ogden Ave., Chicago, Ill.

Michael G. Kemper, 144-1 Sirocco Dr., Minot AFB, N. D.

### SPECIALISTS

James I. Tennenbaum, 113 E. Perimeter Dr., San Antonio, Texas 27—*Allergy*

Fausto Duque, 1033 Ford Ave., Youngstown, Ohio —*Anesthesiology*

Spencer D. Albright III, 1 Berkley Road, Chapel Hill, N. C.—*Dermatology*

Herschel M. Richter, 3425 Lorring Dr., Suitland, Md.—*Internal Medicine*

Gordon L. Doty, 10-A Michael Rd., Randolph, Mass. —*Internal Medicine—Cardiology*

Eugene H. Siegel, 1643-A Birch St., Fort Dix, N. J.—*Internal Medicine*

Gerald E. Vallee, Henry Ford Hospital, Detroit, Mich.—*Internal Medicine*

R. Paul Clodfelder, 1312 Northfield, N. E., Grand Rapids, Mich.—*Internal Medicine*

Harold E. Toussaint, 2814 Wyoming, Bremerton, Wash.—*Ob-Gyn*

J. Frederick Walk, 131 Cain Ave., DeRidder, Louisiana—*Ob-Gyn*

John C. Parker, 75-R Avenue H South, Glasgow AFB, Montana—*Ob-Gyn*

Hau Ngoc Vu, 568 Moore Dr., Campbell, Ohio— *Ob-Gyn*

Stuart M. Meyer, 1247 North and South Road, University City, Mo.—*Orthopedics*

David M. Harvey, 3366 Wedgewood Dr., Augusta, Ga.—*Orthopedics*

Manuel R. DeLeon, 804 E. McClure, Peoria, Ill.— *Pathology*

Pyrrha G. Grodman, 1111 Clairmont Ave., Apt. J4, Atlanta, Ga.—*Pathology*

Bernard P. Rudis, 5822-A Brett Dr., Fort Knox, Ky.—*Pediatrics and Pediatric Neurology*

Robert L. Argue, 962 Renfrew Bay, Winnipeg, Manitoba, Canada—*Radiology*

Nathaniel Silon, 150 Dartmouth St., Rochester, N. Y. 14607—*Radiology*

Edward K. Davis, 12 Vista Rd., Englewood, Col. 80110—*Radiology*

Teofilo M. Manzanero, Homer Folks Tuberculosis Hospital, Oneonta, N. Y. 13820—*General and Thoracic Surgery*

Gilbert D. Klickstein, 147 Woolsey Ave., Glen Cove, N. Y.—*General Surgery*


# ANNUAL CLINICAL CONFERENCE

## CHICAGO MEDICAL SOCIETY

**Palmer House, Chicago**

**March 1, 2, 3 and 4, 1965**

**THIS CONFERENCE IS DESIGNED TO BE OF INTEREST TO ALL PHYSICIANS.** It is not sectionalized by medical specialties, but by types of disease entities. These will be presented in a manner designed to interest the generalist and specialist alike. All physicians, regardless of their principal areas of practice, should find much in this program which will be informative and useful.

**For program or registration information address:**

**Clinical Conference Committee**
**Chicago Medical Society**
**310 So. Michigan Ave.**
**Chicago, Illinois 60604**

Robert Karger, U. S. Naval Hospital, Oakland, Calif. 94627—*General Surgery*

Joseph L. Farr, 592 St. Claire Dr., Palo Alto, Calif.—*General Surgery or Urology*

Charles J. League, Jr., 6925 W. Lloyd St., Milwaukee, Wisc.—*General and Thoracic Surgery*

Robert L. Dernlan, U.S.P.H.S. Hospital, Seattle, Wash.—*General and Chest Surgery*

John M. Snelling, Jr., 1036 Queens Road West, Charlotte, N. C.—*General Surgery*

Frederick G. Battle, 19 Logan Crescent W., Yorktown, Saskatchewan, Canada—*General Surgery*

Hormoz Minoui, 24 Fairview Ave., Dover, N. J. —*General and Thoracic Surgery*

Francisco D. Deorgracias, 830 Lincoln Park Dr., Cincinnati, Ohio—*General Surgery*

Perry Leon Mathis, 3239 Clements, Detroit, Mich. —*General Surgery*

Antonio B. Donesa, 26 Rhodes Circle, Apt. 314, Birmingham, Ala.—*Neurosurgery*

Floyd R. Overby, 9926 Queen Ave., South, Minneapolis, Minn.—*Urology*

Thomas W. Weis, 319 W. College Ave., Waukesha, Wisc.—*Administrative & Pharmaceutical Industry*

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### *Bids Asked for Construction of First Phase of I.U. Buildings*

Indiana University has advertised for bids for construction of the $13.5 million first phase of a six-story teaching and research hospital for adult patients at the I.U. Medical Center in Indianapolis.

Identified as Phase I of what eventually will be a 713-bed hospital, the construction will provide for 249 beds.

J. A. Franklin, I.U. vice-president and treasurer, said construction is scheduled to start shortly and be completed in 1966.

A total of $6.1 million of the cost was appropriated by the General Assembly. The remainder came from Federal grants and from a major gift by Mr. and Mrs. Herman C. Krannert of Indianapolis. Krannert is chairman of the board of Inland Container Corp.

Their gift will provide for the 25-bed Krannert Pavilion, which will enable private patients, upon referral by their own physicians, to have available the medical care and treatment of the advanced medical teaching and research center.

The pavilion will be operated on a self-supporting basis as are all patient services in the medical center, as required by statute.

In an earlier announcement, President Elvis J. Stahr compared this facility to Phillips House, a special private-care section of the Massachusetts General Hospital in Boston, and the Harkness Pavilion, the private patient-care section of the Columbia University Presbyterian Hospital in New York.

Still in the planning stage is the remaining portion of the teaching-research hospital costing an estimated $11.3 million, of which the General Assembly will be asked to appropriate $5 million in each of the next two bienniums.

When completed in all phases, the hospital will include 146 beds in obstetrics and gynecology; 468 for medical-surgical care; 21 for psychiatric patients; 45 in intensive care; eight overnight holding beds and the 25-bed Krannert Pavilion.

### *Joseph D. O'Brien Appointed Medical Board Administrator*

Joseph D. O'Brien has been appointed administrator of the State Board of Medical Registration and Examination.

Mr. O'Brien, 49, was formerly associated with the Indiana State Police and was stationed in the southwest part of the state. Leaving the state police with a rank of lieutenant, Mr. O'Brien had been with them for 23 years. He formerly resided in Jasper, is married but has no children.

### Indiana Marriage Laws Changed By Chapter 130, Indiana Acts 1957

Chapter 130, Indiana Acts 1957 made considerable changes in the Indiana marriage laws. It provided for a "three full day waiting period" from the time the application is made until the license to marry can be issued by the clerk of court. The Attorney General has ruled that a "full day" is 24 consecutive hours of the same date. The date the application is made does not apply to the three-day waiting period, therefore the waiting period does not begin until the first midnight after the application has been filed.

The former marriage law did not provide for a waiting period, but specified that the blood sample and report must be sent through the U. S. mails thereby constituting a waiting period. Under the 1957 law, the blood sample may be taken to an approved laboratory and the results given to the physician or applicant immediately after the test is finished, subject to the administrative practice of the laboratory.

Further information regarding the provisions of the 1957 Indiana marriage law may be obtained from the Indiana State Board of Health, 1330 W. Michigan Street, Indianapolis or from any county clerk.

### *KSMA Changes Name*

The House of Delegates of the Kentucky State Medical Association have approved the deletion of the word "State" from the name of their association. In future the KSMA will be known as the Kentucky Medical Association.

### New CPC Motion Picture Now Available to Physicians

A new CPC motion picture, the second of its type designed to permit audience participation and discussion of a special clinical case, is now available on free loan from the Wm. S. Merrell Company, Cincinnati, Ohio.

The new film entitled "Clinico-Pathological Conference at Cook County Hospital" presents an un-

Continued



# "Gesundheit!"

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Each layered tablet contains:

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Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

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rehearsed case description and differential diagnosis from this leading medical teaching center.

The film is divided into two parts on a single reel. Between parts one and two, the projector may be stopped while the audience discusses the case and each physician makes his own diagnosis. Part two of the film reveals the tissue findings, both gross and microscopic, and the final case summary is presented.

The single reel, 16 mm. color-sound motion picture has a total running time of 38 minutes. Part one (case presentation) has a running time of 20 minutes—part two (pathology and case summation) runs 18 minutes.

Merrell provides the audience with a printed protocol of the case containing a sealed section which includes pathology and final diagnosis.

Also available from Merrell—"Clinico-Pathological Conference at Philadelphia General Hospital"—a 39 minute, color-sound motion picture presented in the same classic medical education technic as a "live" CPC. Each of Merrell's CPC films offer a stimulating challenge to medical students and physicians to arrive at the correct diagnosis of a special case.

Hospitals, medical schools and medical societies may obtain more information on the free loan of a CPC motion picture by writing to Director of Professional Relations, the Wm. S. Merrell Company division of Richardson-Merrell Inc., Cincinnati, Ohio 45215.

## *"Overweight" Pamphlet Now Available to Physicians*

"Overweight—A Problem for Millions" is the title of a new Public Affairs pamphlet, available at 25 cents per copy and for less in quantities. The 20-page booklet, by Michael H. K. Irwin, M.D., explains the problem of obesity and its management in lay terms.

It is easily understandable and would make an ideal educational item for any patient who should lose weight. To order: Write Public Affairs Pamphlets, 381 Park Ave. South, New York City 10016.

## *Dr. Nicoll Receives Grant*

Dr. Paul A. Nicoll of the department of physiology at I.U. Medical Center is the recipient of a grant of $21,180 from AMERF for research on the effect of tobacco smoke on the peripheral circulation.

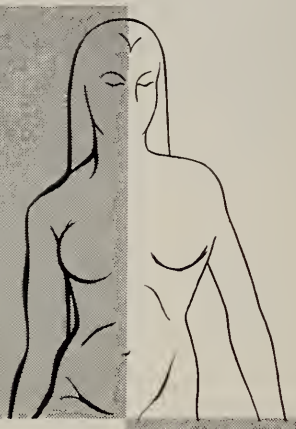
## Quarterly Bulletin Published by Methodist Hospital of Gary

The Methodist Hospital of Gary has entered the publication field. Under the able guidance of the co-editors, W. P. Loh, M.D. and G. N. Lewis, M.D. the first two issues of the *Quarterly Bulletin of*

emphatic dietary reform with little C. N. S.** stimulation

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(Releasing the drug over a 6-10 hour period)

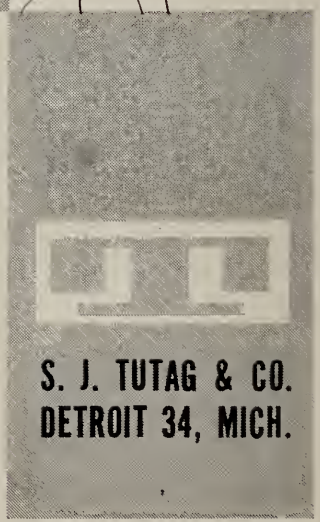
Each **CYDRIL** (levamfetamine succinate) Tablet contains:
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**Side Effects:** Rare—C.N.S.** stimulation minimal, occasionally cardiovascular and gastrointestinal reaction may be observed.
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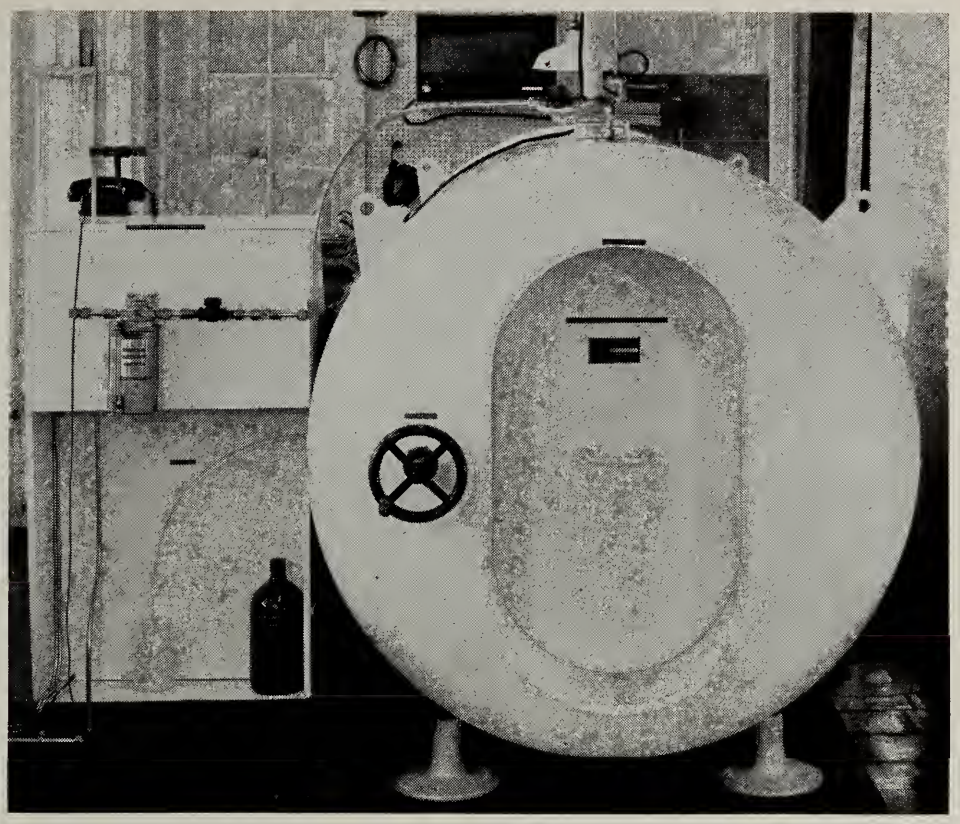
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**HYPERBARIC THERAPY units, like the one here, manufactured by Biggs-United division of United Sheet Metal Co., will be marketed by the National Cylinder Gas division of Chemtron Corporation. The chamber, first in this country specifically designed for hyperbaric therapy and large enough to house two or more people, is a single compartment designed for compressed air service and tested for 100-pounds-per-square-inch working pressure. There are three chambers in the NCG-Biggs line, providing operating suites up to 42-feet long and 10 feet in diameter. Custom chambers can be supplied on special order.**

*the Methodist Hospital of Gary, Inc.* have been published.

The *Bulletin*, which is the official organ of the staff of the hospital, has as its aim the enhancement of communication between the staff and the hospital administration, encouragement of the staff to submit scientific papers which are of benefit to others and to make Methodist Hospital better known to other hospitals and communities.

If the two issues published so far are any criteria, this new publication should be a great success. The quality of content is extremely high and although the *Bulletin* is small, it is well printed and generous space has been allowed for the illustrations.

The subscription rate is $4.00 per year; single copies are available at $1.00 each. Subscription checks should be made payable to the *Quarterly Bulletin of the Methodist Hospital of Gary, Inc.*

## Salesman Wins Award

William E. Shannon of Indianapolis, a salesman for Warner-Chilcott Laboratories, was one of eight men selected from around the country to receive a Bobst Scholarship Award. The award is in the form of a $2,500 scholarship fund for the children of the recipient and is given in recognition of professional and private achievements.

## *Medical Assistants Must Apply For 1965 Exams by February 1*

Medical assistants wishing to sit for the 1965 national certification examination given by the American Association of Medical Assistants must file their applications before February 1.

Mrs. Mary Kinn, Santa Ana, California, chairman of AAMA's Certifying Board, which administers the examination, advises medical assistants interested in the test to obtain application blanks by writing AAMA's national office, 510 North Dearborn Street, Chicago 60610.

## Dr. Craft Re-elected Editor

Dr. Kenneth L. Craft, of Indianapolis, was re-elected editor of the Transactions of the American Society of Ophthalmologic and Otolaryngologic Allergy at the recent annual meeting of the society in Chicago.

## *Dr. Bissonnette Re-elected*

Dr. Roger P. Bissonnette of Evansville was re-elected as Governor by the American College of Gastroenterology at its recent annual meeting in New York City.

## *Topics Announced for National High School Essay Contest*

The Association of American Physicians and Surgeons is conducting the 19th renewal of the National Essay Contest for High School students.

The topics for the 1965 contest are "The Advantages of Private Medical Care" or "The Advantages of The American Free Enterprise System over Communism." Medical societies are invited to sponsor the local contests. There is a total of $2,675.00 in national prizes with a $1,000.00 first prize and $500.00 second prize, and others to a total of ten. ◄

# FUTURE MEETINGS, SEMINARS, COURSES

## *Laryngology, Bronchoesophagology Course Set for March 29-April 10*

The Department of Otolaryngology, College of Medicine, of the University of Illinois will conduct a postgraduate course in laryngology and bronchoesophagology from March 29 through April 10. This course, limited to 15 physicians, will be under the direction of Paul H. Holinger, M.D., and will be held at the new Illinois Eye and Ear Infirmary, 1855 West Taylor Street, Chicago.

Instruction will be provided by means of animal demonstrations, and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures. Interested registrants should write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, 1853 W. Polk St., Chicago 60612.

## Ophthalmology, Otolaryngology 18th Annual Meeting Set for April 18-21

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 18th annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia on April 18-21.

A registration fee of $35 for associate members will cover all social and scientific sessions. For additional information, please contact the secretary, Worthy W. McKinney, M.D., Professional Park, Beckley, West Virginia.

## *Mayo Clinical Reviews Will Be In Two Sections Again This Year*

The Mayo Clinic will conduct its annual "Clinical Reviews" in two sections this year on March 15, 16 and 17, and March 22, 23 and 24. Similar programs have been presented for many years and are increasingly popular; 900 physicians attended last year.

The meetings will be held in the theater of the Mayo Civic Auditorium in Rochester. Credit is given by the American Academy of General Practice and the registration fee is $10.00. Advance and early registration is advised since the number who can be accommodated is limited. Write M. G. Brataas, Mayo Clinic and indicate which session is preferred.

## University of Colorado Lists Postgraduate Courses in Medicine

Postgraduate courses in medicine will be presented by the University of Colorado School of Medicine as follows: Management of Trauma, March 3-5, 1965; Clinical Dermatology, April 15-17; Cardio-Pulmonary Diseases, April 26-30; Psychiatry for the Internist, June 14-18; Religion and Medicine Conference, June 14-16; Pediatrics, Aug. 2-6; and Internal Medicine, Aug. 9-13. For details address the Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

## *ISMA Members Invited to "Resident's Day" in Detroit*

All members of ISMA are invited to attend the seventh annual "Resident's Day" in Obstetrics and Gynecology, conducted by Wayne State University, on Wednesday, March 24. The meeting will begin at 8 a.m. and will terminate by 8:30 p.m., at the Wayne County Medical Society Bldg., 1010 Antietam St., Detroit.

A group of distinguished obstetricians and gynecologists will conduct the program. There is no registration fee, luncheon tickets are $1.50, dinner tickets $5.00. Advance registration is requested. Write Dr. Charles Stevenson, Wayne State University School of Medicine, 1500 Chrysler Expressway, Detroit 7.

A special feature of the meeting is an invitation to any physician to submit biopsies of endometrium, ovary or testis from an infertile patient for use in a panel discussion on infertility. Microscopic slides and a history of the case should be sent to Dr. Stevenson prior to mid-February. Whether the material is used by the panel or not, a written opinion will be rendered free of charge. Residents and interns are especially welcome. Hospitals may register house officers and provide for their meal tickets by writing Dr. Stevenson.

## Tutorial Program in Cardiology Offered by Scripps Clinic

A nine-month tutorial program in Cardiology, September 15, 1965 to June 15, 1966, will be offered by the Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, California.

This will be an intensive program covering the field of cardiovascular diseases and is especially designed for the physician in private practice who wants an academic year of organized instruction with freedom from direct patient responsibility. For details, write: E. Grey Dimond, M.D., Institute for CardioPulmonary Diseases, Scripps Clinic and Research Foundation, La Jolla, California.

## *"Expanded Surgery of the Nasal Septum" Course Set for April*

An introductory course in "Expanded Surgery of the Nasal Septum" will be presented at the Methodist Hospital Graduate Medical Center, Indianapolis, April 21 to 24.

Drs. Carl B. Sputh, Lewis E. Morrison and Sydney L. Stevens of Indianapolis and Dr. Walter J. Aagesen of Anderson, as well as a large instructional staff from all over the United States, will conduct the instruction. A preliminary program

and other information may be obtained by writing the American Rhinologic Society, 530 Hawthorne Pl., Chicago 60657.

## Midwestern States Symposium On Noise in Industry Scheduled

A two-day symposium on Noise in Industry will be offered on February 4 and 5, 1965 in Cincinnati, Ohio. Nationally known speakers will discuss various aspects of this growing industrial health problem. Tuition is $35 per person which includes two lunches and a dinner. The featured speaker at the dinner meeting will be Dr. Aram Glorig who will discuss "Medicolegal Aspects of Noise."

For further information, contact Mrs. Adelaide Badgley, secretary, Institute of Industrial Health, at Kettering Laboratory, Eden and Bethesda Avenues, Cincinnati 45219.

## *Gastroenterology Symposium Is Set by Georgia College*

A continuing medical education symposium on gastroenterology will be presented March 31 - April 2 at the Medical College of Georgia, Augusta, Georgia. The guest faculty includes three nationally recognized teachers and clinicians who will join with members of the Medical College of Georgia faculty in discussing the medical and surgical approach to problems in gastroenterology.

Sports-minded physicians are reminded that this symposium immediately precedes the Masters Golf Tournament which will be played at the Augusta National Golf Club, April 4-11. For a symposium brochure listing the subjects to be discussed and participating faculty, write to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

## American Ob-Gyn Board Lists Application Data

Candidates who have participated in the Part I (written) examination of this Board given on December 11, 1964 will be notified of the results of their examination on or before February 1.

Applications for the Part I (written) examination to be given on July 2, 1965, will be accepted in the office of the secretary during the months of January and February. All applications postmarked after February 28th will be returned to the sender. Application forms and bulletins of the board may be obtained by writing to the office of the Secretary, - Clyde L. Randall, M.D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

## Arizona Cancer Seminar Will Be March 17-20 in Tucson

Members of ISMA are invited to attend the Arizona Cancer Seminar at the Pioneer Hotel in Tucson from March 17 to 20. A distinguished faculty will conduct the scientific program.

Further information and a copy of the program may be obtained by writing American Cancer Society, 4700 N. 12th St., Phoenix 85014. ◄

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## PSYCHIATRY FOR THE MEDICAL PRACTITIONER

**New Orleans, Louisiana**

**March 4-6, 1965**

Sponsored by the DIVISION OF NEUROLOGY AND PSYCHIATRY OF TOURO INFIRMARY under a National Institute of Mental Health Grant.

GUEST LECTURERS INCLUDE:

**Jack Ewalt, M.D.**, Prof. of Psychiatry Harvard Med. School, Past Pres. of American Psychiatric Association, Boston, Mass.

**John Lambert, M.D.**, Medical Director, Four Winds Hospital, Katonah, N. Y.

**Zigmond Lebensohn, M.D.**, Chief, Dept. of Psychiatry, Sibley Memorial Hospital, Washington, D.C.

**William Sheeley, M.D.**, Director of Psychiatry & Medical Practice Project of the A.P.A., Washington, D.C.

**Philip Solomon, M.D.**, Chairman, A.P.A. Committee on Medical Practice, Boston, Mass.

Course will be given at Jung Hotel, 1500 Canal Street, New Orleans, La. Hotel reservations to be made directly with the Jung or hotel of your choice. Registrants who would like to enjoy Mardi Gras (March 2) are urged to make hotel reservations *immediately.*

Guest speaker for the luncheon on March 4 will be **George Burch, M.D.**, Henderson Professor and Chairman, Dept. of Medicine, Tulane Medical School. Subject: "Emotions and Cardiovascular Disease." Cost of luncheon included in registration fee. At the end of Friday's session, there will be a dutch treat two-hour cocktail party with George Lewis and his band from Preservation Hall entertaining.

AMONG TOPICS TO BE DISCUSSED:

"Detection of Incipient Psychiatric Disorders During a General Medical Examination"

"Medical Practitioners and Supportive Handling of Schizophrenia"

"Adolescents — Disturbed and Disturbing"

"The Physician and His Reaction to the 'Crock'"

"Newer Thoughts About the Therapy of Alcoholism"

"Medical Conditions with Psychiatric Manifestations"

"Recognition and Treatment of Depressive Reactions by Medical Practitioners"

"Treatment of Emotional States by the Medical Practitioner"

Gene L. Usdin, M.D., Chief
Division of Neurology & Psychiatry
Touro Infirmary
3516 Prytania Street
New Orleans, La. 70115

Enclosed is my registration fee of $20 for the "Psychiatry for the Medical Practitioner" course to be given March 4-6, 1965, at the Jung Hotel. (Checks should be made payable to the Touro Infirmary.)

Name .....

Address .....

.....

# Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1965 annual meeting of the Indiana State Medical Association, Oct. 12-14 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

---

## Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

_____



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| (Warning: May be habit-forming) | 6.5 mg. |
| Homatropine methylbromide . . . . . 1.5 mg. | |
| Pyrilamine maleate . . . . . | 12.5 mg. |
| Phenylephrine hydrochloride . . . . . | 10 mg. |
| Ammonium chloride . . . . . | 60 mg. |
| Sodium citrate . . . . . | 85 mg. |

(with methylparaben 0.13% and propylparaben 0.02% as preservatives)

*in a highly palatable cherry-flavored vehicle*

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**DOSAGE:** *Average adult dose*—1 teaspoonful after meals and at bedtime with food. *Children 6-12 years,* ½ teaspoonful; *3-6 years,* ¼ teaspoonful; *1-3 years,* 10 drops; *6 months to 1 year,* 5 drops. Administer after meals and at bedtime with food. **On oral Rx where state laws permit.**

**CAUTION:** Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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# County, District News

## Carroll

Dr. Eldon E. Baker, Delphi, is the newly elected president of the Carroll County Medical Society. Other new officers are: Drs. Max R. Adams, Flora, vice-president; Robert M. Seese, Delphi, secretary-treasurer and T. Neal Petry, Delphi, delegate.

## Cass

Members of the Cass County Medical Society elected the following officers at their Dec. 7 meeting: Drs. Francis W. Parker, Jr., president; R. H. Maschmeyer, vice-president; E. L. TerBush, secretary-treasurer; E. W. Bailey, delegate and D. K. Winter, alternate. All of the new officers are from Logansport.

## Clinton

Dr. Harry T. Stout is the new president of the Clinton County Medical Society. Dr. Milton W. Erdel is the new vice-president and Dr. Earl K. Williams, secretary-treasurer. All of the new officers are from Frankfort.

## Dearborn-Ohio

Dr. Kitzmiller, dermatologist from Cincinnati, discussed "Common Skin Disorders and Their Treatment" with the 13 members of the Dearborn-Ohio County Medical Society present at the Dec. 3 meeting.

## Decatur

Elected as officers for 1965 by the Decatur County Medical Society are Drs. Robert P. Acher, Greensburg, president; E. A. Porter, Westport, vice-president; James C. Miller, Greensburg, secretary-treasurer; William Shaffer, Greensburg, delegate and Dr. Acher, alternate.

## De Kalb

Newly elected officers of the De Kalb County Medical Society are: Drs. John Harvey, Auburn, president; C. A. Novy, Garrett, secretary-treasurer; Bradley Hughes, Waterloo, delegate and Clifford Schultz, Butler, alternate.

## Elkhart

"Moose" Krause, Notre Dame's athletic director, was guest speaker at the December meeting of the Elkhart County Medical Society.

## Fulton

Dr. Joseph D. Richardson, Rochester, is the newly elected president of the Fulton County Medical Society. Dr. Howard Rowe and Dr. Wayne L. Knockle, both of Rochester, will serve as vice-president and secretary-treasurer, respectively.

## Grant

The Grant County Medical Society has elected the following as new officers for 1965: Drs. John G. Rhorer, president; Douglas A. Bailey, president-elect; Robert G. Young, secretary-treasurer; Robert M. Brown, delegate and Lester L. Renbarger, alternate. All of the officers are from Marion.

## Harrison-Crawford

Dr. Samuel W. Martin is the new president of the Harrison-Crawford County Medical Society. Assisting him will be: Drs. Louis H. Blessinger, vice-president; Wilfred J. Brockman, secretary-treasurer; Dr. Martin, delegate and Dr. Brockman, alternate. All of the new officers are from Corydon.

## Howard

New officers of the Howard County Medical Society are: Drs. Powell L. Perkins, president; R. L. Michael, first vice-president; Charles F. Smith, second vice-president; John DeBrota, Jr., secretary-treasurer and Warren N. McClure, delegate. All of the officers are from Kokomo.

## Huntington

Dr. Joseph H. Clark, Huntington, is the newly elected president of the Huntington County Medical Society. Other officers include: Drs. Reeve B. Peare, Huntington, vice-president; Carl S. Ray, Warren, secretary-treasurer; Richard W. Wagner, Huntington, delegate and Warren Van Campen, Huntington, alternate.

## Koscuisko

The new president of the Koscuisko County Medical Society is Dr. Carl E. Shrader. Other officers are: Drs. Edgar A. Reed, vice-president; Thomas F. Keough, secretary-treasurer; William J. Cron, delegate and Dr. Keough, alternate. All of the officers are from Warsaw.

## Newton

Members of the Newton County Medical Society have elected the following as new officers: Drs. M. F. Guzman, Morocco, president; L. E. Kresler, Kentland, vice-president; Arthur Schoonveld, Brook, secretary-treasurer; R. S. Yegerlehner, Kentland, delegate and John C. Parker, Goodland, alternate.

## Noble

Dr. J. R. Nash, Albion, is the new president of the Noble County Medical Society. Assisting him will be Drs. Herman Hepner, Kendallville, vice-president; Joseph Greenlee, Avilla, secretary-treasurer; Robert E. Bryan, Kendallville, delegate and Donald J. Hooker, Ligonier, alternate.

## Pike

Dr. Milton H. Omstead, Petersburg, has been

re-elected president and delegate of the Pike County Medical Society.

## Pulaski

The Pulaski County Medical Society has elected the following as their 1965 officers: Drs. John D. Lacy, Jr., Medaryville, president; E. L. Hollenberg, Winamac, secretary-treasurer and William R. Thompson, Winamac, delegate.

## Putnam

Dr. V. E. Wiseman is the new president; Dr. F. R. Dettloff, vice-president and Dr. Anne S. Nichols, secretary-treasurer of the Putnam County Medical Society. All are from Greencastle.

## Shelby

Newly elected officers of the Shelby County Medical Society are: Drs. Robert Spindler, president; Roger Whitcomb, vice-president; Paul Inlow, secretary-treasurer; Wilson Dalton, delegate and John Davis, alternate. All of the officers are from Shelbyville except for Dr. Davis, who is from Flat Rock.

## White

The White County Medical Society new officers are: Drs. David C. Beck, Monticello, president; W. V. Morris, Monticello, vice-president; Wayne W. Houser, Monon, secretary-treasurer; W. Martin Dickerson, Monticello, delegate and Nolan A. Hibner, Monticello, alternate.

## Whitley

Dr. John L. Vogel is the new president of the Whitley County Medical Society. Other officers are: Drs. John Wilson, vice-president; Donald B. Reid, secretary-treasurer; Thomas Hamilton, delegate and C. Jules Heritier, alternate. All of the new officers are from Columbia City. ◄

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# Deaths

## George R. Daniels, M. D.

Dr. George R. Daniels, president of the Indiana State Medical Association in 1928, died Dec. 28 at Richmond at the age of 86.



Dr. Daniels, born at Sweetser, Indiana, was a descendent of a long line of Hoosier physicians. He was graduated from the old Indiana Medical College in 1900 and began the practice of medicine with his father at Sweetser. He moved to Marion in 1904 and practiced medicine there until he retired three years ago. Dr. Daniels was mayor of Marion from 1922 to 1926 and had served as Grant County coroner and health officer.

During his long career in medicine, Dr. Daniels held many positions with ISMA including: president of the Eleventh District; secretary of the Grant County Medical Society; member of the committees on Administration and Medical Defense, Public Policy and Legislation, Budget, Physician-Patient Relations and Grievance and was chairman of the Committee on Convention Arrangements.

Dr. Daniels was a Senior Member of ISMA and made a member of the 50-Year Club in 1950. In 1953, he represented Indiana at the First Western Hemisphere Conference of the World Medical Association in Richmond, Va. Along with physicians from other states who were 75 years old that year, Dr. Daniels was honored by leaders of the medical societies of the United States and Latin America.

### Franklin C. Dielman, M.D.

Dr. Franklin C. Dielman, 85, a practicing physician in Fulton for 60 years, died Dec. 10 at the Woodlawn Hospital there.

The oldest practicing medical doctor in Fulton County, Dr. Dielman was graduated from the University of Illinois in 1904 and began practicing in his home community of Macy. He moved to Fulton shortly thereafter. He had been on the staff of the Woodlawn Hospital since its beginning in 1905.

### Fletcher Hodges, M.D.

Dr. Fletcher Hodges, retired Indianapolis physician, died Dec. 5 in his home at the age of 85.

The son of a well-known physician, Dr. Hodges began his practice in the old family home. Later he had offices in the Hume Mansur building. He was graduated from Harvard University in 1902 and from the old Indiana Medical College in 1904. A member of the Marion County Medical Society, Dr. Hodges was made a member of the ISMA 50-Year Club in 1952.

### Samuel W. Hooke, M.D.

Dr. Samuel W. Hooke, 79, a physician at Noblesville for 46 years, died Nov. 29 at Riverview Hospital there.

A native of Bowling Green, Ky., Dr. Hooke was graduated from the old Indiana Medical College in 1909. He went to Noblesville around 1918 and retired in 1950. Dr. Hooke served as a captain in the Army Medical Corps, was a member of the Hamilton County Medical Society and the ISMA 50-Year Club.

### Eva N. Kennedy, M.D.

Dr. Eva N. Kennedy, 82-year-old Camden physician, died Nov. 12 after being injured in an auto accident while she was en route to attend a patient.

Dr. Kennedy had practiced in the Camden area for more than 50 years. She attended Purdue University and was graduated from the old Indiana Medical College in 1906. A member of the Carroll County Medical Society, Dr. Kennedy was named to the 50-Year Club in 1956.

### Clarke E. Orders, M.D.

Dr. Clarke E. Orders, member of the staff of St. Francis Hospital at Indianapolis for 40 years, died Nov. 2 at the age of 85.

Member of the Marion County Medical Society and the 50-Year Club, Dr. Orders attended Ohio Northern University for premedical training and was graduated from the University of Louisville School of Medicine in 1907. He had also been on the staff of Community Hospital since it opened. ◄

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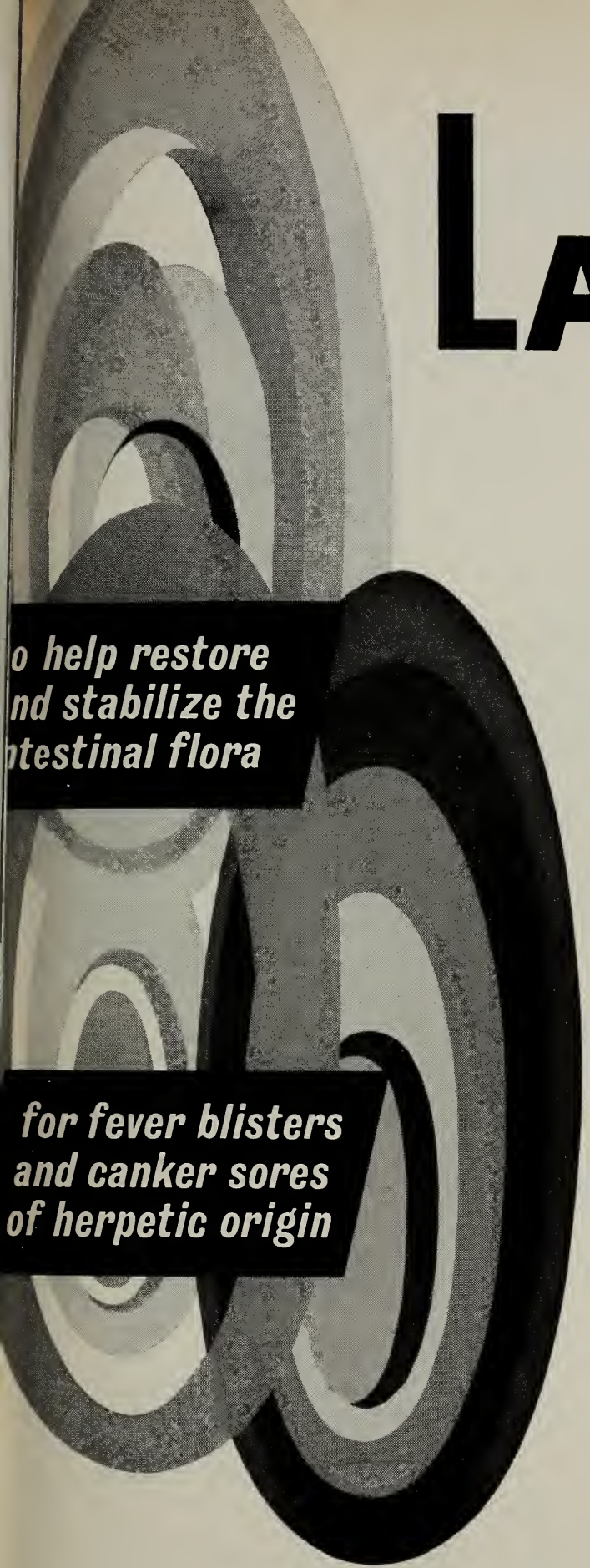
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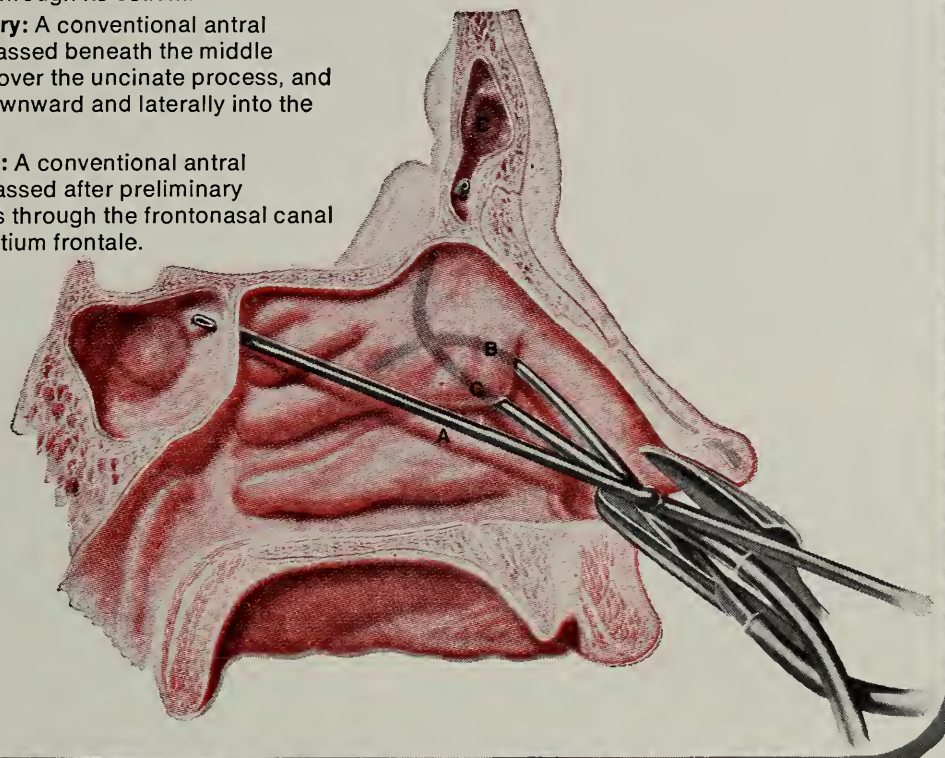
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| 8. | Warren L. Bergwall, Muncie | David J. Dietz, Muncie | Muncie, 1965 |
| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | Frankfort, May 20, 1965 |
| 10. | Michael Shellhouse, Gary | Edward J. Dierolf, Gary | |
| 11. | Fred C. Poehler, La Fountaine | Max M. Earl, Kokomo | Peru, Sept. 15, 1965 |
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# in maintenance therapy... a working analgesic for the active arthritic

## ARTHRALGEN®

Each tablet contains:

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| Salicylamide | 250 mg. |
| Acetaminophen | 250 mg. |
| Ascorbic acid (Vitamin C) | 25 mg. |

**a working analgesic for the active arthritic**

—rapidly relieves early morning stiffness and arthritic pain. It promises a quicker response in most patients because its analgesic ingredients need no metabolic conversion before they act. As a combination of two prominent analgesic drugs, Arthralgen can often establish smoother, more complete pain relief because it synergistically produces more efficient analgesia on lower dosage levels of each.

**two proven pain relievers**

Arthralgen combines two better-tolerated, time-tested analgesics, acetaminophen and salicylamide, into a pharmacologically sound and therapeutically effective formulation. As Arthralgen, it penetrates tissues promptly and relieves pain rapidly with less likelihood of gastric irritation than aspirin.

**sodium-free**

Arthralgen contains no sodium. Therefore, it is often a safer and more suitable analgesic for use in the long-term treatments of arthritic patients who have other conditions which require sodium restriction.[1]

## ARTHRALGEN®-PR (Arthralgen with prednisone)

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To help provide dosage flexibility in patients who require steroids, the basic Arthralgen formula is also available combined with prednisone as Arthralgen-PR. Prednisone is favored as the more advantageous steroid for use in Arthralgen-PR because it shows less tendency toward sodium retention, potassium excretion, and steroid-induced hypertension than that which often accompanies the use of cortisone and ACTH.[2]

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Arthralgen and Arthralgen-PR are indicated in the management of rheumatoid arthritis, acute gouty arthritis, rheumatoid spondylitis, osteoarthritis, bursitis, fibrositis, and neuritis. Arthralgen may be used for analgesia in colds, flu, and various myalgias.

DOSAGE: One or two tablets four times a day. After remission of symptoms dosage should be reduced to the minimum maintenance level.

SIDE EFFECTS: Nausea, GI upset, or mild salicylism may rarely occur. Symptoms of hypercorticoidism dictate reduction of dosage of Arthralgen-PR.

PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

CONTRAINDICATIONS: Hypersensitivity to any ingredient.

As with any drug containing prednisone, Arthralgen-PR is contraindicated, or should be administered only with care, to patients with peptic ulcer, tuberculosis, nephritis, diabetes mellitus, acute psychoses, Cushing's syndrome (or Cushing's disease), overwhelming spreading (systemic) infection, or predisposition to thrombophlebitis.

Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.

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# Of 425 patients with confirmed G.I. infections... 387 or 91.1% were treated successfully with Signemycin®

**Note:**
Loughlin and co-workers* achieved cure (absence of parasites) in all 100 of their patients with *chronic amebic colitis*. Feces became negative in all within the planned ten-day period of Signemycin administration. Upon re-examination of the feces six weeks later, the offending pathogen *(E. histolytica)* had reappeared in only 7 cases.

*Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960.

| Condition | No. of Patients | No. Responded to Signemycin |
|---|---|---|
| Amebiasis | 237 | 222 |
| Cholecystitis and cholangitis | 105 | 97 |
| Enteritis | 41 | 31 |
| Peritonitis | 15 | 14 |
| Various, including pancreatitis, appendicitis and colitis | 27 | 23 |
| Totals | 425 | 387 (91.1%) |

## consistently effective...often when others fail

# Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

*Brief Summary and Bibliography follow.*

*Science for the world's well-being®* Pfizer *Since 1849*

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## Letter

## to the editor

January 29, 1965

To The Editor:

The editorial by J. F. S. in the November issue of *The Journal* has resulted in a cogent letter of rebuttal or question by Dr. John S. Pearson.

In his letter, Dr. Pearson correctly points out that the abundance of overhead obstacles such as power lines, telephone wires, trees, etc. make universal use of the helicopter of questionable value in urban areas. It would obviously be impossible for a helicopter to safely land and take off from many of our city streets.

He also raises a question concerning the relative safety of helicopter flights. I cannot quote direct figures for him, but believe that this question has been effectively answered in many areas, not the least of which is the fact that the President of the United States is regularly transported from Andrews Air Force Base to the White House by this means of conveyance. Additionally, the accident record of the commercial helicopter operations in cities like New York, Chicago and Los Angeles has been excellent.

Returning to Dr. Pearson's first objection, the menace of the overhead obstacles, it should be pointed out that those who advocate hospital heliports, and helicopter ambulance service, are thinking in terms of rapid transportation of sick and injured individuals from central collecting points, and not necessarily from every street corner or back yard. The continually increasing number of shopping centers with their large parking areas, the school playgrounds, the parking facilities around modern churches, the city parks and many other similar areas would provide a multitude of such prearranged collecting points.

Regular automobile ambulances would carry the patients to such points, where they could be rapidly transferred to the helicopters without being moved from the stretcher on which they were originally placed. They could then be transported within a few minutes over a distance of many miles, reducing significantly the amount of time before definitive therapy could be undertaken.

Although Dr. Pearson's objections are well thought out and well expressed, I believe that he and I will both live to see the day when the helicopter will be a useful adjunct to metropolitan ambulance service. Certainly, with the continuing increase in automotive traffic on the city streets, changes must, and will, be made. ◄

Yours sincerely,
Dan L. Urschel, M.D.
Immediate Past-President,
The Flying Physicians
Association, Inc.

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# Of 748 patients with confirmed G.U. infections... 684 or 91.4% were treated successfully with Signemycin®

**Note:**
The efficacy of Signemycin was shown in a study of nongonococcal urethritis involving over 1600 patients.* A comparison of the cure rates of sixteen antibiotic and chemotherapeutic agents revealed that Signemycin had the highest incidence of successful response. One hundred and six patients were treated, of which 82 were followed, with cures in 70.

*Willcox, R. R. and Rosedale, N.: Brit. J. Vener. Dis. 38:19, Mar., 1962.

| Condition | No. of Patients | No. Responded to Signemycin |
|---|---|---|
| Cystitis | 29 | 25 |
| Pyonephritis | 30 | 28 |
| Pyelocystitis | 119 | 112 |
| Prostatitis | 14 | 13 |
| Gonorrhea | 66 | 64 |
| Lymphogranuloma venereum | 96 | 96 |
| Syphilis | 31 | 31 |
| Urethritis, nonspecific | 149 | 131 |
| Various, including infections seen with impaired urinary flow or lithiasis | 214 | 184 |
| Totals | 748 | 684 (91.4%) |

## consistently effective...often when others fail

# Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Ear, nose and throat infections | 507 | 465 |
| Respiratory infections | 1,028 | 954 |
| Gastrointestinal infections | 425 | 387 |
| Genitourinary infections | 748 | 684 |
| Skin and soft-tissue infections | 1,088 | 1,036 |
| Bone and joint infections | 71 | 64 |
| Deep-seated or generalized infections | 257 | 251 |
| Obstetrical & gynecological infections | 341 | 320 |
| Miscellaneous conditions | 592 | 570 |
| Totals | 5,057 | 4,731 (93.5%) |

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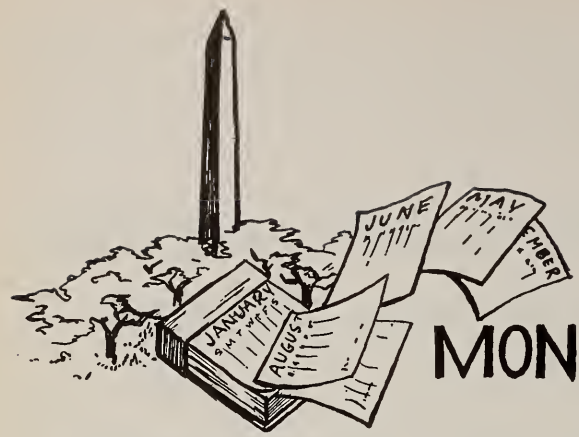
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This summary of what is happening in Washington is prepared by A.M.A.'s Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D. C.—President Johnson has asked Congress to approve a far-reaching program of diagnosis, treatment and stepped-up research on heart disease, cancer, stroke and "other major diseases."

In a health message to Congress, the President also urged speedy passage of a Social Security health plan for aged persons.

The outline of his wide-ranging program was the president's first message on legislation sent to the new Congress. He sent it to Capitol Hill on the fifth day of the new session.

Johnson requested in addition to "Medicare":

—An increase in federal funds for maternal and child health and crippled children's services and broadening of public assistance programs so federal money could be used to pay medical and dental costs for children of needy families.

—Approval of a five-year program of grants to help start community mental health centers to offer comprehensive services.

—A step-up in the program to rehabilitate disabled persons so 145,000 could be restored to useful work each year.

—Establishment of multi-purpose regional medical complexes for diagnosis and treatment of heart disease, cancer, stroke and other major diseases. This proposal envisions, under a five-year program, a network of 32 centers coordinating efforts of medical schools, hospitals and community facilities costing an estimated $1.2 billion.

—Federal funds to improve services for the mentally retarded, increase hospital modernization and start a new program of loans and guarantees for loans to help voluntary associations build group medical practice centers.

—New legislation to help medical and dental schools cover basic operating costs with federal funds.

—Federal scholarships for medical and dental students.

—Extension for five years, after mid-1966, of federal health research programs with a greater emphasis on specialized research of a national or regional nature.

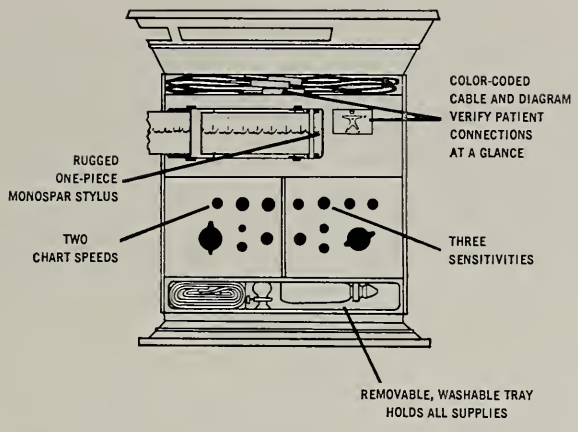
—Laws to bring the production and distribution of so-called "goof-ball" pills—barbiturates, amphetamines and other psychotoxic drugs—under tighter control and legislation to require adequate labeling of hazardous substances and safety regulation of cosmetics and therapeutic devices by the Food and Drug Administration.

## "NEW" KING-ANDERSON BILL

Prior to the health message, Sen. Clinton P. Anderson (D., N.M.) and Rep. Cecil R. King (D., Calif.) already had introduced medicare legislation to carry out the President's program. It was S-1 in the Senate and HR-1 in the House. It was a modified version of the King-Anderson bill which died in a joint House-Senate conference committee last year after the

Continued

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Senate had voted 49-44 to add it to a House measure increasing Social Security cash benefits.

The new King-Anderson bill calls for bringing self-employed physicians under Social Security coverage. It also would increase Social Security cash benefits by seven percent. In a benefit period, all persons 65 years or older would be eligible under the health care plan for 60 days of hospitalization with the patient paying for the first day and 60 days of post-hospital care in a nursing home. Generally, 90 days would have to intervene between benefit periods.

Aged persons also would be eligible for up to 240 days a year of home health services, such as a visiting nurse, and certain outpatient diagnostic services with the patient paying a monthly deductible. Nursing home benefits would start January 1, 1967, and the other benefits July 1, 1966.

Social Security taxes would be increased by .3% next year, .38% in 1967-68 and .45% in 1969 and following years on employees and employers for a separate fund to finance the program. The tax base also would be increased to $5,600.

The program would be administered through Social Security by the secretary of Health, Education and Welfare. Hospitals could elect to be represented by a private organization, such as Blue Cross, to negotiate their contracts. The secretary would also delegate to such organization the functions of receiving payments from the Social Security program. Payments would be made to hospitals and other providers of services on a cost basis. The cost of hospital services would be based on semi-private accomodations (2, 3, or 4 bed rooms).

The bill also would authorize creation of an association of private insurance carriers to sell, on a nonprofit basis, approved policies covering health costs not covered under the Social Security plan. Participating carriers would be exempt from anti-trust laws.

Administration officials said Johnson's health proposals, other than medicare, would cost $262 million in the year starting next July and more than $800 million in the following 12 months.

Officials said the entire package, including the five-year program to establish regional medical centers to combat heart disease, cancer and stroke, would cost several billion dollars spread over this decade.

The plan for helping with the medical bills of needy children would be similar to the existing Kerr-Mills program for helping needy aged persons pay medical expenses. Aides said $100 million would be earmarked for the first year of the new program and $250 million the following year.

## PRESIDENT GETS CLEAN BILL OF HEALTH

President Johnson started his four-year term in the White House in excellent health and physically able to withstand the stresses and strains of the office "in outstanding fashion," according to his physician.

Rear Adm. George G. Burkley, White House physician, made the favorable report on the President's health in the form of 35 answers to questions submitted by newsmen.

He said he keeps a close eye on the President daily and gives him a general examination every seven to 10 days.

Burkley said Johnson, who had a kidney stone removed in 1955, cut down on his calcium intake by drinking less milk after a slight recurrence of kidney trouble in 1963. "There has been no kidney trouble since mid-1963," Burkley reported.

Burkley attributed the President's ability to carry on a rigorous routine, despite his 56 years and 1955 coronary thrombosis, to "complete recovery

with excellent general physical fitness and ability to relax on short notice."

The doctor reported that Johnson has a daily supervised health routine at the White House "augmented by walking and at times, swimming." He added that "a supervised exercise program is done in his bedroom."

Johnson normally retires around midnight, Burkley said, and his normal bedtime is "infrequently" put off because of work. He said Johnson gets seven to eight hours sleep and that he sleeps well. He usually awakens between 7 and 8 a.m., and later takes a nap. He occasionally "does some work" in bed.

Johnson is on "no special diet" and likes a highball before dinner. He has not smoked since his 1955 heart attack. His weight has been between 205 and 210 pounds, but Burkley—like other physicians who have examined Johnson—would like him to keep his weight "in the 200 pound area."

## UPSWING OF VENEREAL DISEASES

With about 30 of the largest U.S. cities experiencing syphilis epidemics, health authorities are expressing more and more concern about a resurgence in venereal diseases.

Some experts in the field believed 10 years ago that venereal disease would be wiped out by this time through treatment with penicillin and other so-called "wonder drugs."

But it has not worked out that way. Why? Pointing to sharp increases in venereal disease among teen-agers, some say a general decline in the morals of the nation's youth is a major factor. Other reasons given by public health officials include:

—Steadily increasing urbanization of the population—the movement to the big cities, where venereal disease rates have always run highest.

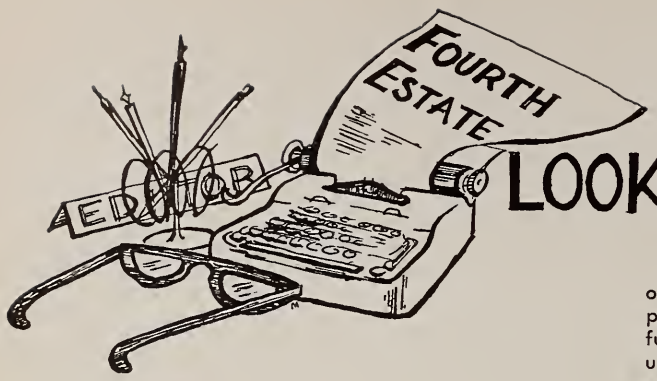
—Increased mobility of the population, such as in migrant labor groups, and the increased use of the airplane and automobile–permitting the diseases to spread much faster.

—False feelings of security against the threat of venereal disease following introduction of the "wonder drugs." But many people don't make use of the cure after they have had exposure, especially in the case of syphilis, where early symptoms may pass unnoticed.

Public Health Service venereal disease experts say the upsurge in both syphilis and gonorrhea "is not confined to any race, sex, socio-economic group or geographic area" but has occurred generally throughout the nation. ◄

## From *The Journal* 50 Years Ago

> . . . The present Indiana pharmacy law permits any person who has had four years' experience in a drug store where prescriptions are compounded to appear before the State Board of Pharmacy and take the examination for full registration, and, what is worse, a large percentage of such applicants without professional training are successful in becoming registered.
>
> It is the boast of a pharmacy quiz course that it can so prepare these men in ten weeks that 96% of them are able to pass the State Board examinations. There is little incentive for a person to secure a good college training when he is placed on a par, in the eyes of the law, with a person who has perhaps sold Kodaks and soda water for four years and taken a ten-weeks' quiz-compend cram course in pharmacy . . . C. B. Jordan, Ph.C., M.S., "How to Advance Pharmacy in Indiana", *JISMA*, February, 1915.




# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## An Unwise 'Solution'

Like motherhood, apple pie and furry puppies, any legal move to crack down on those who illegally trade on the public's physical and psychological ailments can hardly be attacked in any conscience.

This is why the Indiana Psychological Association's proposed bill to require the licensing of psychologists has received virtually no opposition to date. This is unfortunate. Because it is a long way from being what it is advertised as being.

Without impugning the association's motives, or its desire to drive untrained, potentially dangerous "quacks" out of the highly complex field of psychology, the proposed legislation, as it is now written, is a bad bill at worst; a foolish bill at best.

It would, indeed, drive the quacks who trade on the troubled and the emotionally disturbed out of business. But the bill is so loose in its definition of what constitutes "the practice of psychology" that it covers virtually every conceivable instance in which one individual might counsel, advise or subject another to a test of his "abilities, aptitudes, personality characteristics, emotions, motivation and opinions." Only a psychologist holding a Ph.D. degree, or otherwise accredited by the state's new five-man board, would be permitted to do so.

Even broader is the bill's definition of psychology as "any service involving the application of established principles, methods and procedures of understanding, predicting, or influencing the behavior of persons or groups, such as the principles pertaining to learning, motivation, perception, thinking, emotions and interpersonal relationships."

The former definition would require every company personnel director and private employment agency to maintain a staff Ph.D. in psychology to administer even the simplest test to a job applicant covering his aptitudes and job skills. And the latter would cast suspicion on the right of sales organizations, advertising agencies, or even newspapers, to engage in business without a psychologist's services because all of these endeavors dispense services involving the "understanding, predicting or influencing," of "the behavior of persons or groups."

To carry it to an illogical extreme, the bill could even be used as a club over the head of the factory foreman who counsels a worker on how to get along with his fellow-employees. It could be a threat against the right of a father to tell his son why the youngster has started noticing girls. Both qualify as instances of "interpersonal relationships."

We are sure that the association's intentions are good, and that some sort of legal curb on the quacks who hang up a shingle proclaiming themselves to be "psychological consultants" is, indeed, needed. The proposed law, however, clearly invades areas of the personnel field—to name only one—in a way that is unneeded, unwise, overly generalized and, possibly, even unconstitutional. All of this under the guise of driving out of business the unqualified clinical practitioner.

Of the 14 states now having laws governing the licensing of psychologists, only three do not specifically exclude normal personnel testing from their definition of what constitutes "the practice of psychology." Indiana would do well to follow suit.—*Indianapolis Star,* Jan. 11, 1965 ◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 58 — February 1965 — Number 2

# Supernormal Excitation of the Human Heart

PAUL L. McHENRY, M.D.
SUZANNE B. KNOEBEL, M.D.
*Indianapolis**

THE USE OF artificial pacemakers in patients with advanced heart block has given us the opportunity to observe clinically the existence of the supernormal period (SNP) of excitation first described by Adrian and Lucas[1] in a nerve-muscle preparation. This period for the ventricle is a brief one, following the relative refractory period during which a subthreshold stimulus will give a propagated response (Figure I).

Supernormal excitability was first demonstrated in the mammalian heart by Hoff and Nahum[2] and later confirmed by others.[3] It was not, however, actually documented in man until recently.[4,5,6]

The following case report clearly demonstrates the phenomenon.

### Case Report

The patient, a 70-year-old female, was admitted for the first time to the Indiana University Medical Center on June 10, 1964 for implantation of a cardiac pacemaker. Her illness dated back to January, 1962, when she noted the onset of dyspnea on exertion, accompanied by weakness, dizziness and recurrent episodes of syncope. At that time she was admitted to another hospital for four weeks and treated medically for complete heart block. There was some alleviation of symptomatology. In April, 1964, she had a recurrence of symptoms, was hospitalized and again improved on a medical regimen. However, the syncopal episodes recurred and she was admitted to this center for definitive therapy.

Physical examination revealed a blood pressure of 165/50 mm Hg. The pulse rate was 36 per minute and slightly irregular. The pertinent physical findings were related to the heart. The PMI was just outside the mid-clavicular line in the fifth interspace. There was no abnormal left ventricular activity. A grade II/VI systolic ejection murmur was heard at the base. All routine laboratory studies were within normal limits. The chest x-ray revealed mild left ventricular cardiomegaly and ectasia of the thoracic aorta. An electrocardiogram showed complete A-V dissociation with an atrial rate of 55 per minute and an idioventricular rhythm with a rate of 35 per minute. Occasional ventricular premature systoles were also present (Figure II-A).

The patient was taken to surgery on June 12, 1964 and implantation of a cardiac pacemaker was carried out. Her postoperative course was uneventful and she was dis-

* From the Division of Cardiology, Department of Medicine and the Heart Research Center, Indiana University School of Medicine and the Krannert Heart Research Institute, Marion County General Hospital, Indianapolis.

Supported by the Herman C. Krannert Fund, the Indiana Heart Association, Indiana State Board of Health and (in part) by the U.S. Public Health Service Training Grant 5363 and (in part) with facilities provided by the Cardiovascular Clinical Research Center Grant H-6308 from the National Heart Institute, National Institutes of Health, U.S. Public Health Service.

Dr. McHenry is a trainee of the National Heart Institute.

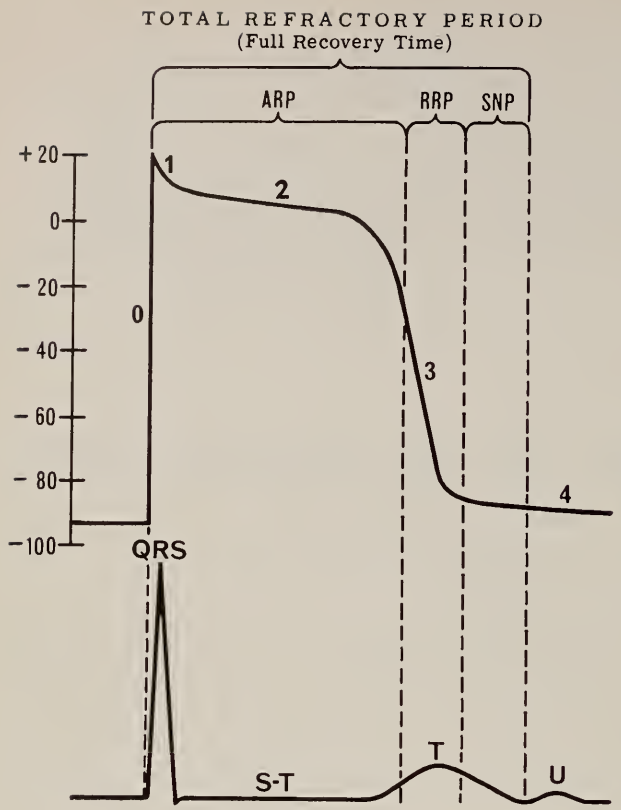



**FIGURE 1**

**THE MONOPHASIC action potential and the electrocardiographic cycle illustrating the areas in each corresponding to the absolute refractory period (ARP), the relative refractory period (RRP), the supernormal period (SNP) and the total refractory period or full recovery time.**

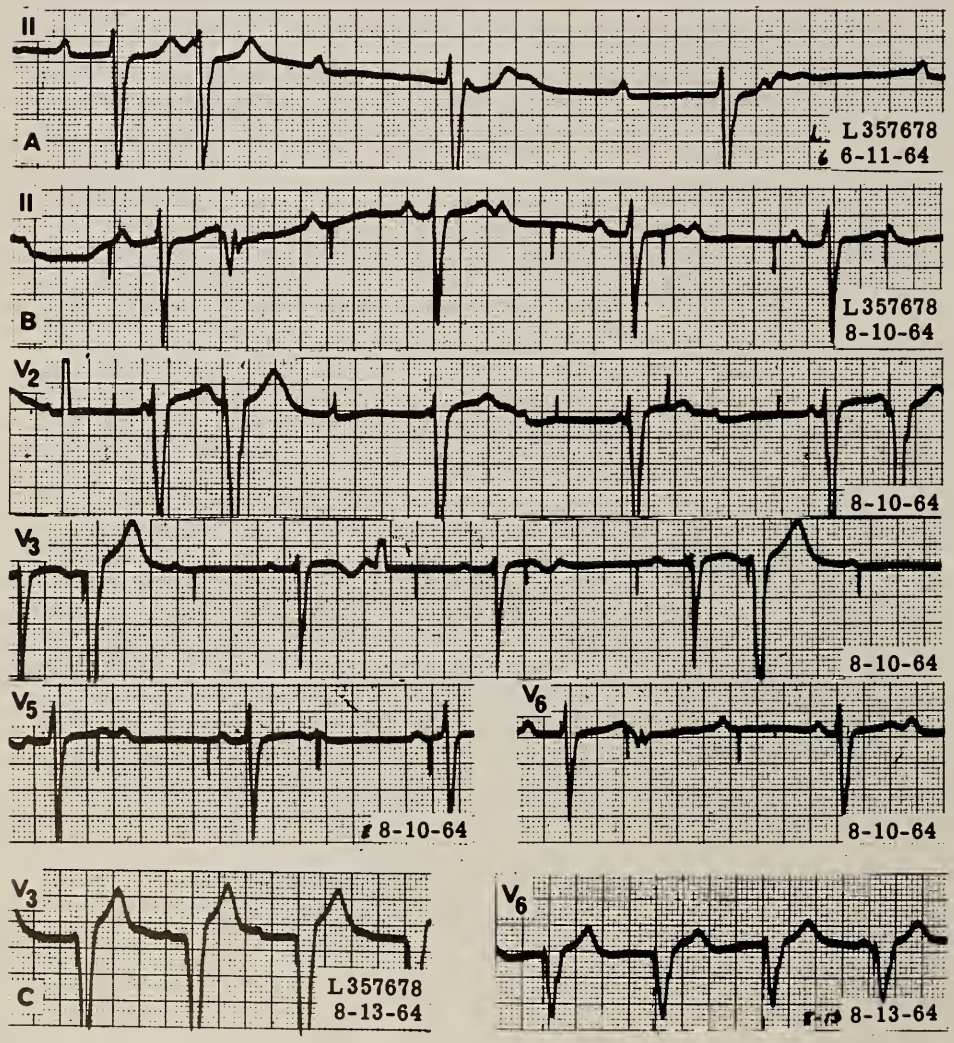



**FIGURE II**

**A. LEAD II of tracing taken during first admission.**

**B. Leads II, V2, V3, V5 and V6 of tracing taken after failure of the implanted cardiac pacemaker. Response occurs to the pacemaker stimuli only during the supernormal period.**

**C. Leads V3 and V6 show regular response to the pacemaker after correction of the malfunctioning pacemaker.**

charged seven days later.

The patient was readmitted to the I.U. Medical Center on August 10, 1964, because of increasing weakness, dyspnea on exertion and dizziness without syncope of two weeks duration. Physical examination showed the blood pressure to be 215/90 mm Hg; the heart rate was 38 per minute. Otherwise the findings were the same as on the original admission. The surgical scars over the left hemithorax and abdomen were well healed.

The electrocardiogram again revealed complete A-V dissociation with an idioventricular rate of 38 per minute. Internal pacemaker impulses could be seen at the regular rate of 72 per minute; but they give rise to a ventricular response only when falling within the supernormal period of recovery of the idioventricular QRS complexes (Figure II-B).

The patient was taken to surgery, the chest was opened and the pacemaker exposed. Modifications to increase the milliamperage were made on the wires leading to the pacemaker electrode but the electrode was not disturbed. The postoperative course was again uneventful and the electrocardiogram showed the heart to be regularly paced at 72 per minute (Figure II-C).

## Discussion

As previously stated, the supernormal period of excitation for the ventricle is a brief interval following the relative refractory period during which a subthreshold stimulus will give rise to a propagated response. With respect to the ventricular monophasic action potential, the supernormal period is included in phase three and its termination coincides with full recovery (Figure I).[7] On the electrocardiogram, the supernormal period of ventricular excitation begins just after the peak of the T wave and ends near the peak of the U wave.[6] In man, the duration appears to be 150 milliseconds or less, varying proportionally with the strength of the subthreshold stimulus.[5] Supernormality is said to exist because of a brief period prior to full repolarization when the transmembrane potential is reduced while the threshold potential remains the same as it is in diastole or phase four.[7]

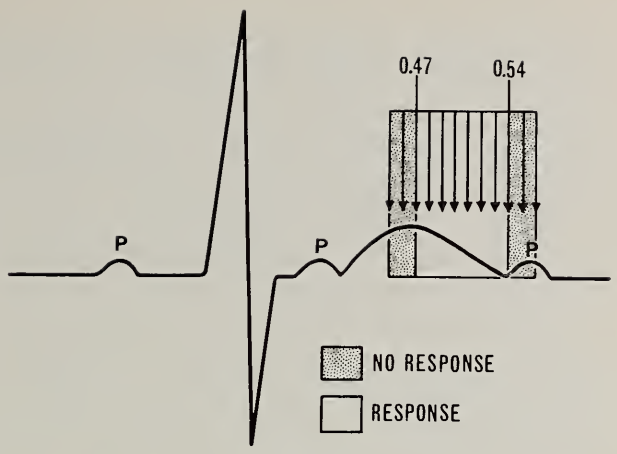



**FIGURE III**

**THE QRS-T cycle of the electrocardiogram with graphic illustration of the area where a response (supernormal) occurred to a subthreshold stimulus in the present case report.**

In the present case report, as illustrated in Figure III, stimuli falling earlier than 0.46 seconds or later than 0.55 seconds after onset of the idioventricular QRS complexes do not give rise to a ventricular response. All stimuli falling in the interval of 0.47 to 0.54 seconds do give rise to a response.

These records also demonstrate latency and aberration of ventricular response occurring as a result of subthreshold stimuli falling in the early supernormal period. Examination of lead V3 in Figure II-B reveals that the first stimulus giving rise to a response occurs at 0.51 seconds after the onset of the preceding QRS and the ventricular response follows after a delay of only 0.02 seconds. The second stimulus, however, occurs at 0.47 seconds after the QRS onset and the delay before ventricular response is 0.05 seconds. In lead V6, there is another external stimulus falling early within the supernormal period (0.47 seconds) and again there appears to be a greater stimulus-response interval as compared with those stimuli occurring after 0.48 seconds. Aberration of the ventricular response is also evident (Lead V6 in Figure II, B, C).

This increase in the stimulus-response interval to subthreshold stimuli occurring early in the supernormal period has been previously observed[6] but associated aberrancy of ventricular response was not noted. Linenthal and Zoll[5] observed both of these phenomena in the human, i.e., an increased stimulus-response interval (latency) and

aberration of ventricular response, with suprathreshold stimuli in the relative refractory period (RRP). Latency and aberration has been demonstrated under similar conditions in experimental animals.[3,7] These observations suggest that similar conditions exist in the early supernormal period with subthreshold stimuli.

In both periods, a stimulus can produce a local excitatory effect which is in some manner maintained until the surrounding myocardium has recovered sufficiently to respond. After sufficient recovery time, the local excitation then gives rise to a propagated wave of excitation. If recovery is uniform and the stimulus is of proper magnitude, it is manifested only by an increase in stimulus-response interval. However, a weaker stimulus or non-uniform recovery of the surrounding myocardium may give rise to aberrant propagation.

It is of interest to note that the ventricular response, whether it be to a suprathreshold stimulus in the relative refractory period or to a subthreshold stimulus in the early supernormal period, occurs at approximately the same time in the cardiac cycle.[5] In experimental animals[7], the response to stimuli in the relative refractory period has been described as occurring after the full recovery time of the ventricle and thus after the supernormal period. However, similar studies with the human ventricle by Linenthal and Zoll[5] demonstrated that responses to stimuli in the relative refractory period fell within the same area on the electrocardiogram as did the supernormal responses. This area also corresponds to the supernormal period observed in this case report (Figure I-B) and in the one by Walker, et al.[6] In all instances, the response occurs on or just after the terminal portion of the T wave. Thus, one might postulate that the point in the supernormal period where a latent response appears to an earlier stimulus marks the end of the true physiological recovery time or phase three and the beginning of phase four of the monophasic action potential. Any aberration of response being manifest at this time can be explained on the basis of non-uniform recovery of different areas of the myocardium.

## Summary

This case report demonstrates that a state of supernormal excitation exists for a brief interval just after the relative refractory period and during the terminal portion of the full recovery time of the ventricle. The activation of the ventricle during the supernormal period does not appear to be uniform for this interval for in the initial few milliseconds of the SNP, a subthreshold stimulus may give rise to a response simulating the response to a suprathreshold stimulus in the RRP, both being manifested by some degree of latency. However, a subthreshold stimulus in the latter part of the supernormal period gives rise to a response more closely resembling that observed after full recovery or phase four.

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# Pectus Excavatum and Cardiovascular Abnormalities

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PECTUS EXCAVATUM (funnel chest) is a congenital anomaly consisting of posterior displacement of the sternum. This displacement results in a depression of the anterior chest wall which is usually deepest just above the xiphosternal junction. The volume of the thoracic cavity is therefore decreased and there are thus variable degrees of compression and rotation of the intrathoracic contents.

Heart murmurs and electrocardiographic abnormalities are quite common in cases of funnel chest.[1] Occasionally significant symptoms related to the cardiovascular and respiratory systems have been reported in this condition.[2] Because of the abnormal auscultatory and electrocardiographic findings, this condition is sometimes confused with other cardiac anomalies such as atrial septal defects, pulmonic stenosis or aortic stenosis. The case reported here is of a patient with minor symptoms, a heart murmur and an abnormal ECG and vectorcardiogram. She underwent cardiac catheterization in order to determine if a cardiac shunt or valvular heart disease was indeed present.

## Case Report

A 15-year-old female student was admitted to the Robert Long Hospital on October 14, 1964, for evaluation of a heart murmur. One year prior to admission, she had consulted a physician because of fatigue of two weeks duration. She was found to be anemic and treated with "iron shots." She was also told that a heart murmur was present and that she had "a hole in her heart." The patient was told to restrict her physical activities. During the succeeding year, she had not undertaken even minor degrees of activity except for attending school.

Her only complaint had been minimal shortness of breath on walking up one to two flights of stairs. She denied chest pain, orthopnea, PND, ankle edema or recognizable episodes of rapid heart beating. Her past history consisted of a hospitalization at age six months for dehydration secondary to vomiting; pneumonia with the measles at age two; tonsillectomy at age three and pneumonia at age nine.

The patient has no siblings. Her father, who is living, had had rheumatic fever. An aunt has a heart murmur and had been told she too had a "hole" in her heart while an eight-year-old nephew had a recent surgical procedure for coarctation of the aorta. The remainder of the family history and social history were non-contributory. The review of systems revealed a minor menstrual irregularity and occasional enuresis, but was not otherwise informative.

Physical examination revealed a normally developed, thin female in no distress. The blood pressure was 110/58 in the right arm recumbent position and 160/100 right leg recumbent; the pulse rate was 96 and regular. The positive findings were confined to the chest and cardiovascular systems. There was a slight pectus excavatum. The PMI was within the mid-clavicular line at the fifth intercostal space. A systolic lift was present in the second left intercostal space

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Drs. Wunsch and Campbell are trainees of the National Heart Institute.

along the left sternal border. The heart sounds were normal with physiologic splitting of the second sound. A grade II/VI systolic ejection murmur was heard over the second and third intercostal spaces to the left of the sternum. The murmur was well localized and did not radiate into the neck.

All routine laboratory studies were normal. The ECG revealed right axis deviation, first degree heart block and right bundle branch block (Figure I). The vectorcardiogram showed a right bundle branch block (Figure II). Cardiac fluoroscopy and chest x-rays revealed a narrow A-P diameter of the thoracic cavity but was otherwise normal (Figure III).

The patient was subjected to cardiac catheterization on October 15, 1964. The pressures in all chambers were normal and oximetric studies did not reveal a shunt. There was a 7 mm gradient across the pulmonic valve during systole. Table I is a summary of the catheterization data.

## Discussion

In a review of 137 cases of pectus excavatum, Schaub and Wegmann[3] found cardiac auscultatory abnormalities in 57%. Systolic murmurs were heard in 33% and splitting of heart sounds or third heart sounds were heard in the remainder. The systolic murmur heard is of the ejection type and is best heard along the left sternal border. The genesis of the murmur is open to question. Since pulmonary systolic murmurs have been reported in these individuals without hemodynamic abnormalities,[4] it is possible that reducing the space between the pulmonary artery and the stethoscope might intensify the sounds. Compression of the great vessels could also account for the murmur. This type of murmur is most often confused with that heard in an

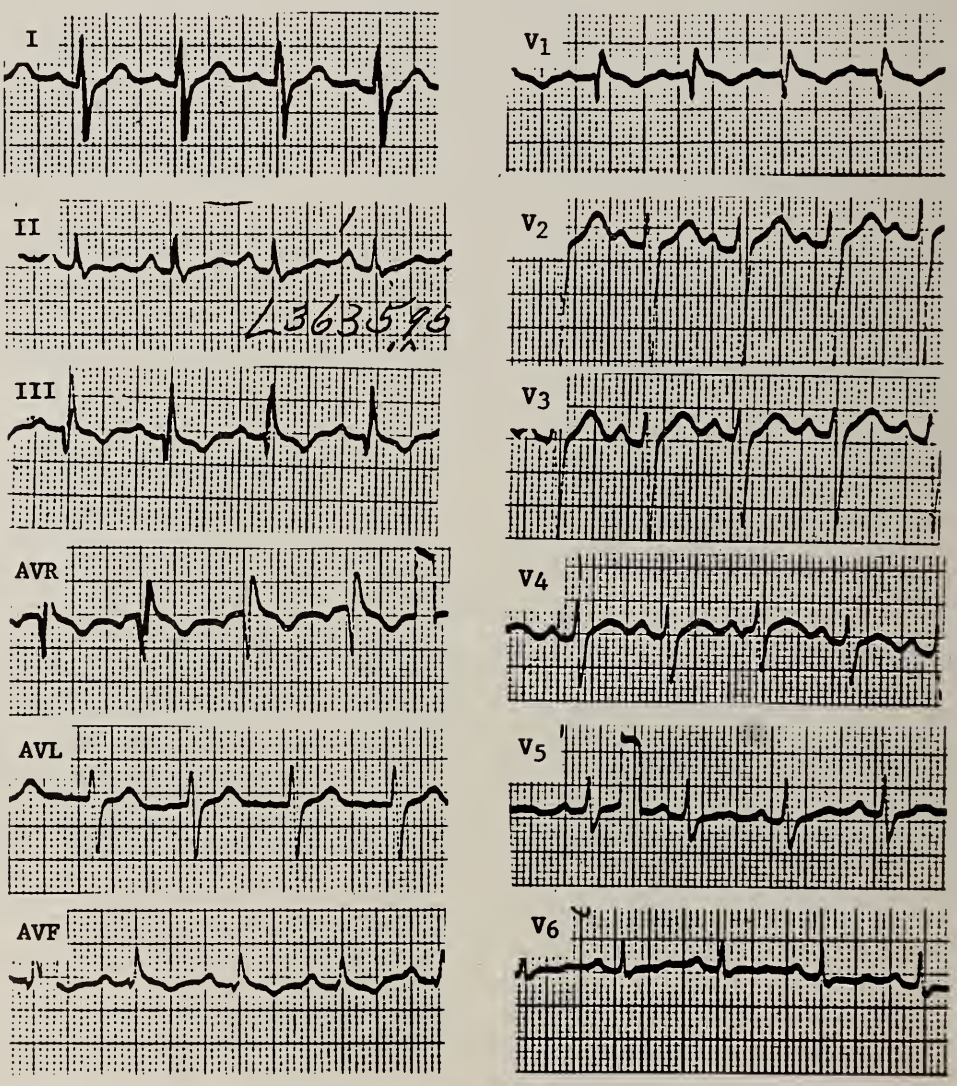



**FIGURE I**
**STANDARD 12 lead electrocardiogram showing a right axis deviation, a right bundle branch block pattern and non-specific ST-T changes.**

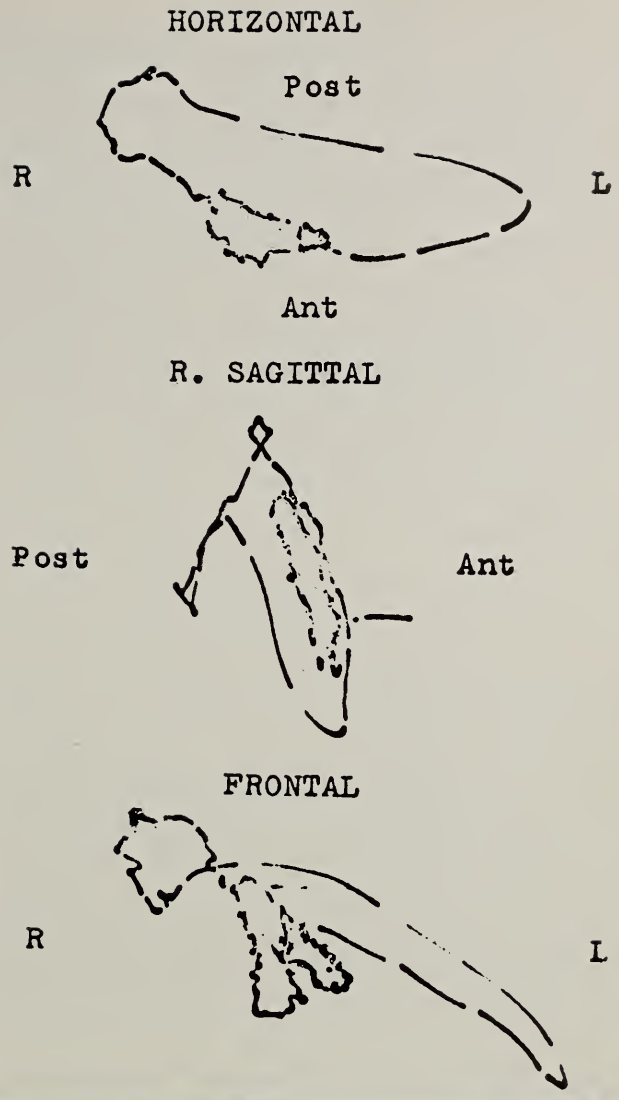



**FIGURE II**

**VECTORCARDIOGRAM done using the cube system. During inscription, the tapered end leads while the rounded end trails. The terminal slowing of the vector and its direction toward the right indicates a right bundle branch block.**

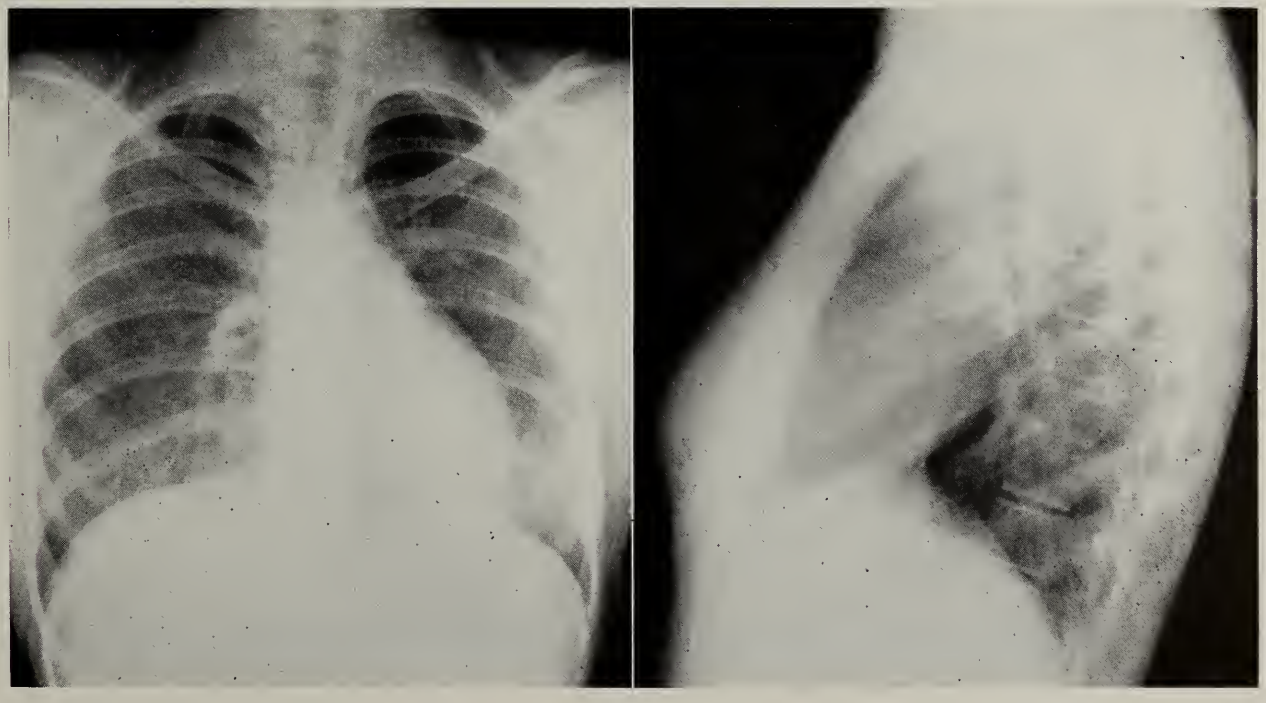


**FIGURE III**

**P-A AND LATERAL roentgenograms of the chest. There is displacement of the heart to the left and slight narrowing of the A-P diameter.**

| HEMODYNAMIC VALUES | | |
|---|---|---|
| | Pressure mm Hg. | $0_2$ Content Vol. % |
| Superior vena cava | | 11.3% |
| Inferior vena cava | | 12.1 |
| Right atrium | a=4<br>v=1 | 12.1 |
| Right ventricle | 22/2 | 11.7 |
| Main pulmonary artery | 14/4 | 11.7 |
| Wedge | 5 mean | |
| Left ventricle | 112/5 | 14.7 |
| Central aorta | 112/86 | |

TABLE I

atrial septal defect of pulmonic or aortic stenosis.

The electrocardiographic abnormalities seen with pectus excavatum are probably due to a displacement of the heart toward the left by sternal pressure. The findings include persistence of the juvenile pattern with T wave inversion across the right sided precordial leads, incomplete right bundle branch block and right axis deviation[5,6]

Symptomatology associated with pectus excavatum is usually minor. Dyspnea on exertion, decrease in exercise tolerance and heart palpitation have been reported.[2] In certain instances, these symptoms have been disabling but have responded to surgical correction of the deformity.[7]

## Summary

A case of a cardiac murmur associated with pectus excavatum is presented. Although the sternal depression may sometimes be associated with severe symptoms, the disability is usually minor. Systolic murmurs and electrocardiographic abnormalities are only occasionally accompanied by significant hemodynamic alteration.

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# Cardiac Catheterization and Indicator-Dilution Curves

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CARDIAC CATHETERIZATION is valuable in the diagnosis of cardiovascular diseases and in physiological investigation. Bleichroeder passed catheters into the arteries and veins of dogs and into his own veins in 1905. In 1925, Forssmann guided a ureteral catheter up his own forearm into the right atrium of his own heart. In 1941, Cournand and colleagues showed that right heart catheterization was a safe and practicable clinical technic.[1]

Because of advances in cardiovascular surgery, it is important to make an accurate cardiovascular diagnosis, especially in congenital and acquired heart diseases characterized by valvular lesions or shunts. Different anatomical lesions require different surgical approaches and technics; therefore an accurate preoperative diagnosis is necessary to help select the best surgical procedure. With a growing surgical experience, rather well defined indications and contraindications to surgical treatment of cardiac lesions become apparent; consequently, an accurate hemodynamic evaluation is necessary to help determine who is a surgical candidate.

## Technic

In our laboratory, in the course of cardiac catheterization, three intracardiac catheters are routinely positioned under fluoroscopic control, after which blood samples for $0_2$ content, pressure tracings, indocyanine green indicator curves and selective cineangiography are performed. In addition, resting and exercise cardiac outputs are determined by both the Fick and dye-dilution technics.

The right heart catheter is introduced into an antecubital vein via a cutdown. A second catheter is introduced into a femoral vein by using the percutaneous technic.[2] This catheter is advanced into the right atrium; the transseptal needle is advanced through the lumen of this catheter. A transseptal puncture is made with the needle and the catheter advanced from the right atrium, across the atrial septum into the left atrium.[3-5] A third catheter is introduced into a femoral artery by using the percutaneous technic. This catheter is advanced in a retrograde fashion and the left ventricle is entered by crossing the aortic valve.

A Cournand needle is then placed in a brachial artery and left in place during the procedure. Right heart blood samples and pressures may be obtained from the right heart catheter. Simultaneous left atrial and left ventricular pressures may be obtained from the transseptal catheter and retrograde left heart catheter respectively. This is especially helpful in mitral stenosis, since the diastolic gradient across the valve may be measured directly. Simultaneous left ventricular and systemic arterial pressures may be obtained from the retrograde catheter and arterial needle. This is especially helpful in aortic stenosis, since the systolic gradient across the valve may be measured directly.

Indocyanine dye-dilution curves help to establish the presence and location of extra and intracardiac shunts. Our usual procedure is to inject the dye into the main pul-

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Dr. Campbell is a trainee of the National Heart Institute.

monary artery and to sample from a brachial artery by using a densitometer. When the dye appears at the brachial artery, the optical density of the blood changes. This change in optical density is detected by the densitometer and a dye curve is written on the oscilloscope.[6]

**Representative Tracings and Curves**

Figure 1 is a normal pressure tracing of the right atrium. Note that there are three distinct waves. The "a" wave is caused by atrial contraction, corresponds to the P of the electrocardiogram and is presystolic in time. The "a" wave is not present in atrial fibrillation. The "c" wave is due to closing of the atrioventricular valve and occurs during the RS segment of the electrocardiogram. The "v" wave is due to atrial filling against a closed atrioventricular valve and occurs late in systole. In right atrial pressure tracings, the "a" wave should always be taller than the "v" wave.[7]

Figure 2 is a pressure tracing of the right atrium in a patient with tricuspid insufficiency. Note that the "v" wave is taller than the "a" wave. In this instance the "v" wave is better referred to as a regurgitant wave.

Figure 3 is a right atrial pressure tracing from a patient with pulmonic stenosis. In pulmonic stenosis the right atrium hypertrophies because it contracts against increased pressure. This is manifested by P pulmonale on the electrocardiogram and by a particularly prominent "a" wave in the atrial pressure tracing.

Figure 4 is a normal pressure tracing of the left atrium. The "a" wave is always taller than the "v" wave in the right atrium; however, in the left atrium, the "a" and "v" waves may be about equal or the "v" wave even be slightly taller.

Figure 5 is a pressure tracing of the left atrium in a patient with mitral insufficiency. Note that the "v" wave, or regurgitant wave, is considerably taller than the "a" wave. When the regurgitant wave approaches ventricular pressure levels, it is referred to as ventricularization of the atrium. Figure 6 is a case of mitral insufficiency with a very prominent "v" wave.

Figure 7 is a simultaneous left atrial and

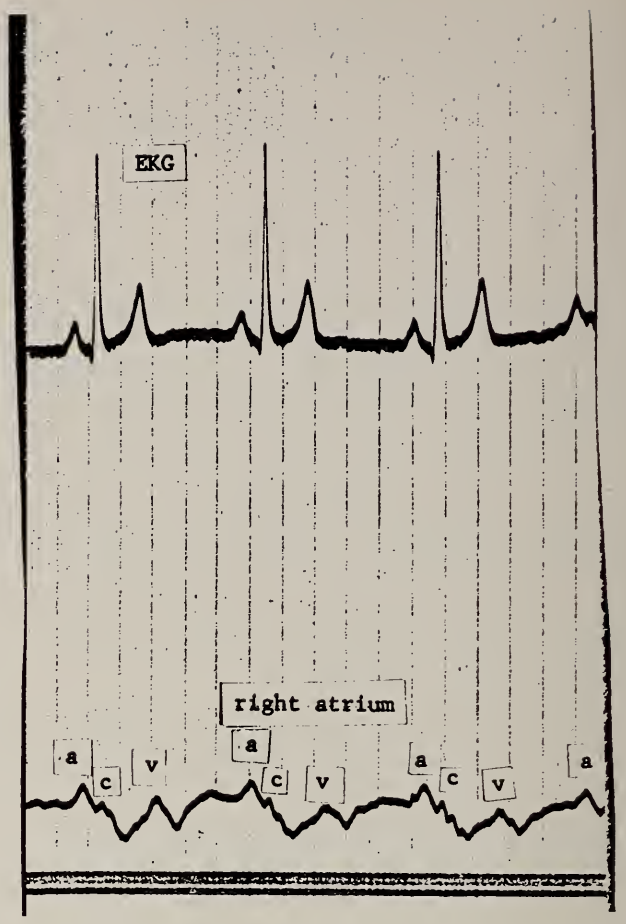



FIGURE 1
NORMAL PRESSURE tracing of right atrium. Note that the "a" wave is taller than the "v" wave.

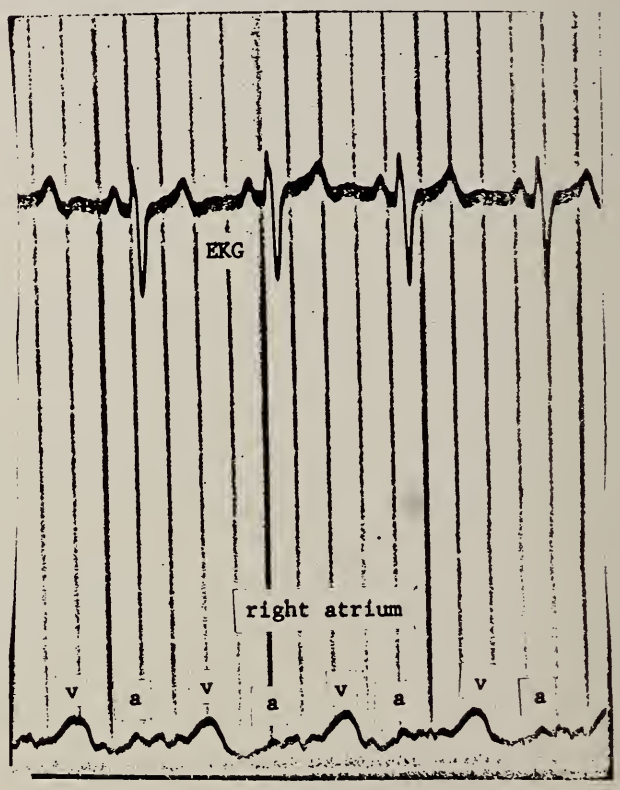



FIGURE 2
PRESSURE TRACING of the right atrium from a patient with tricuspid insufficiency. Note the prominent "v" wave.

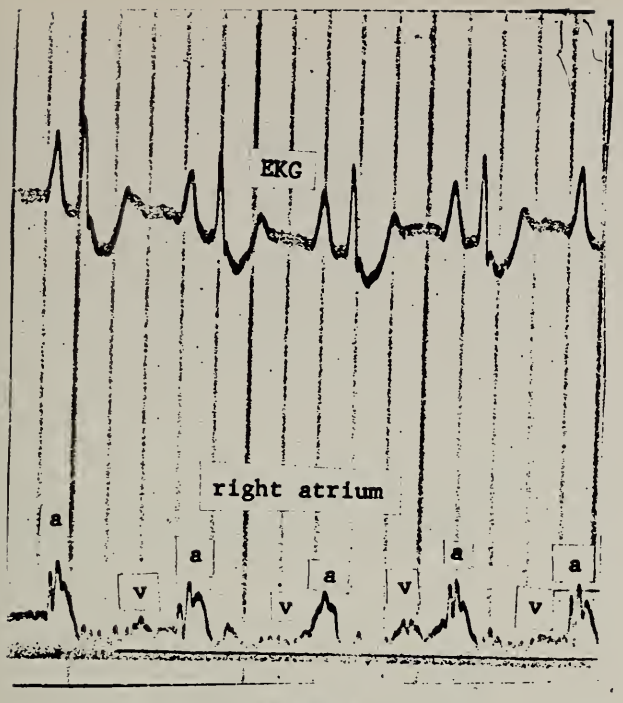



FIGURE 3
PRESSURE TRACING of the right atrium from a patient with pulmonic stenosis. Note the prominent "a" wave.

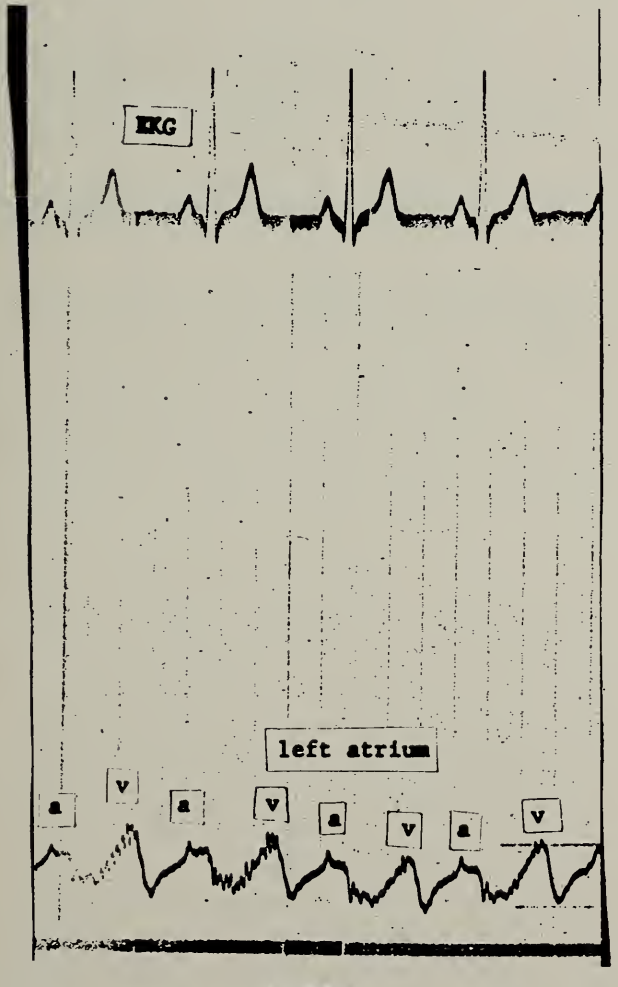



FIGURE 4
NORMAL PRESSURE tracing of the left atrium. Note the "a" and "v" waves are about equal.

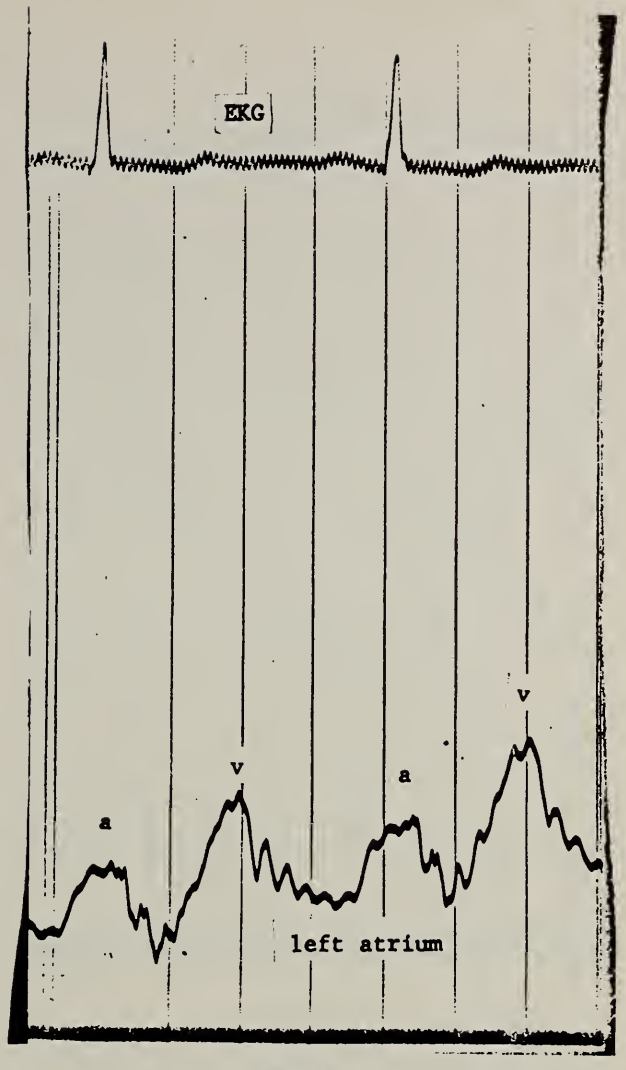



FIGURE 5
PRESSURE TRACING of the left atrium from a patient with mitral insufficiency. Note the prominent "v" wave.

left ventricular pressure tracing from a normal subject. With the transseptal catheter in the left atrium and the retrograde aortic catheter in the left ventricle, simultaneous left atrial and left ventricular pressure tracings can be recorded. Note that there is no diastolic gradient.

Figure 8 is a simultaneous left atrial and left ventricular pressure tracing from a patient with mitral stenosis. Note that there is a diastolic gradient across the mitral valve (i.e., left atrial pressure is significantly greater than left ventricular pressure as shown by the shaded area).

Figure 9 is a simultaneous left ventricular and systemic artery pressure tracing from a normal subject. With the retrograde aortic catheter in the left ventricle and an arterial needle in the brachial artery, simul-

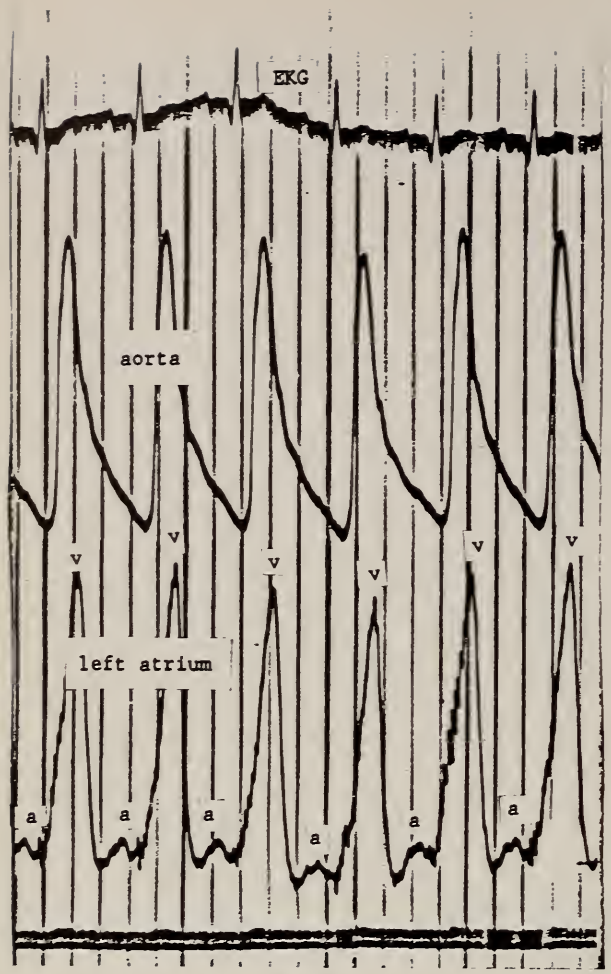



FIGURE 6
PRESSURE TRACINGS of the aorta and left atrium from a patient with severe mitral insufficiency. Note the very prominent "v" wave.

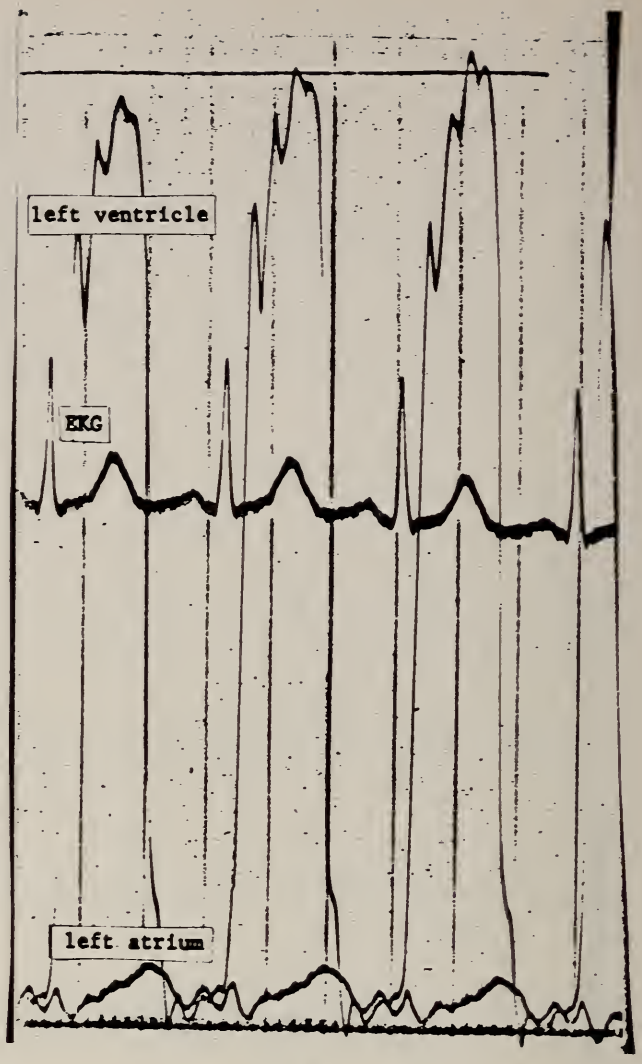



FIGURE 7
SIMULTANEOUS left atrial and left ventricular pressure tracings from a normal subject.

taneous left ventricular and systemic tracings can be recorded. Note that there is no systolic gradient across the aortic valve.

Figure 10 is a simultaneous left ventricular and systemic artery pressure tracing from a patient with aortic stenosis. Note that there is a systolic gradient of 100 mm Hg. across the aortic valve.

Figure 11 is a normal dye curve. The time it takes for the dye to appear at the sampling site after it is injected is the appearance time. Carter[5] and co-workers found that the appearance time was variable. They also found that appearance time was significantly greater in normal adult males than in normal adult females or teen-agers. They related this to the greater body surface area of adult males. They found that when the injection was made in the main pulmonary artery and the sampling done at the radial artery, the mean appearance time in adult males was 11.7 seconds, in adult females 7.0 seconds and in teen-agers 7.5 seconds. When the dye is recirculated and appears at the sampling site a second time, a second deflection on the dye curve is recorded. Carter and co-workers also measured the recirculation time in normal subjects. They used the time between the peak concentration (P) and the peak recirculation concentration (C) as the recirculation time. They found that the mean recirculation time in adult males was 21.4 seconds, in adult females 16.1 seconds and in teen-agers 16.2 seconds.

If a left-to-right shunt is present (e.g., ASD, VSD, patient ductus arteriosus, anomalous pulmonary venous drainage, pulmoaortic window) the shunted dye will be recirculated earlier than normal. Figure 12

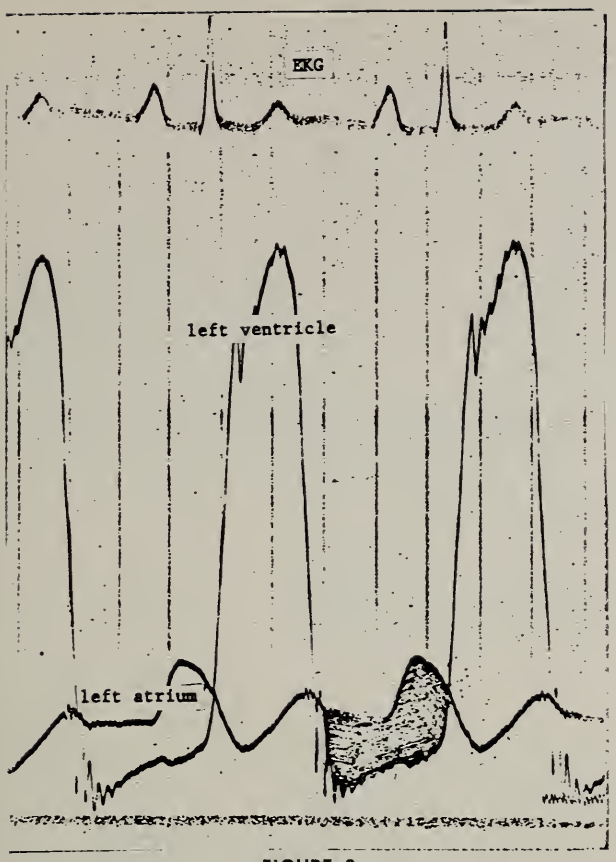



FIGURE 8

**SIMULTANEOUS** left atrial and left ventricular pressure tracings from a patient with mitral stenosis. Note the diastolic gradient (shaded area).

is a dye curve from a patient with an atrial septal defect. The dye was injected into the main pulmonary artery and sampled from the brachial artery. The early recirculation of the dye shunted from left to right is demonstrated by the second hump C. The dye curve in Figure 12 demonstrates a left-to-right shunt but does not locate the shunt precisely. It could be interatrial, interventricular or distal to the aortic valve as in a patent ductus arteriosus.

In order to locate the shunt exactly, more dye curves may be done. Figure 13 shows a dye curve made by injecting the dye into the left ventricle and sampling from the brachial artery. The second hump C represents early recirculation. This informs us that a left-to-right shunt is still present at or distal to the ventricles. This is an example of a ventricular septal defect.

Figure 14 shows a dye curve made by injecting the dye into the ascending aorta and sampling from the brachial artery. The second hump C, represents early recirculation, informing us that a left-to-right shunt

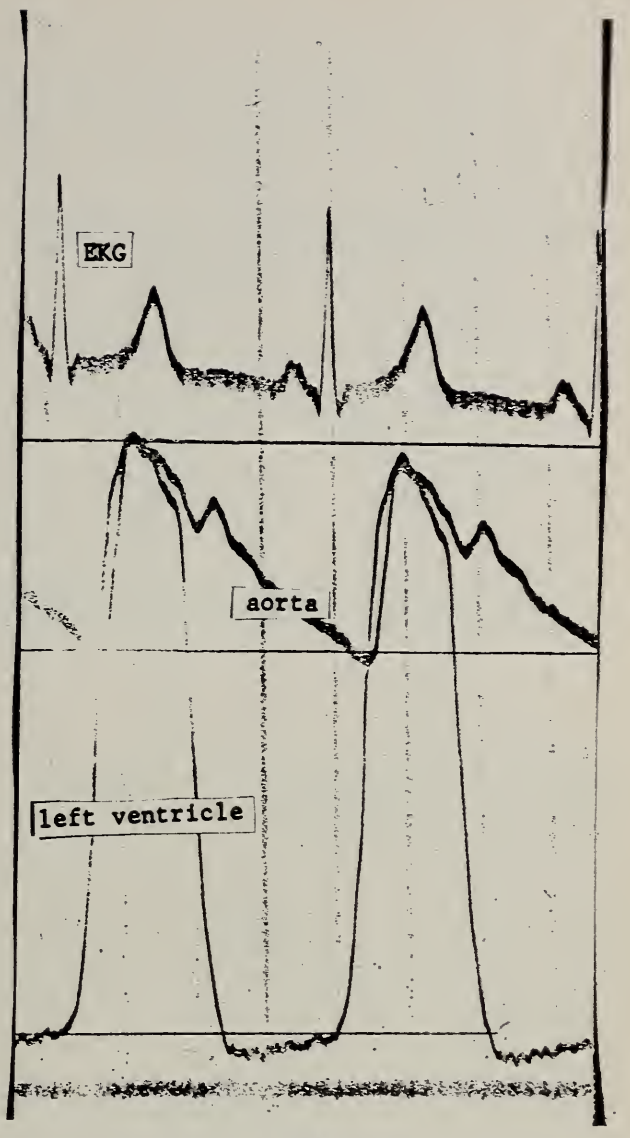



FIGURE 9

**SIMULTANEOUS** left ventricular and aortic pressure tracings from a normal subject.

is still present at this level, (i.e., distal to the aortic valve). This is an example of a sinus of Valsalva aneurysm that ruptured into the right atrium. A patent ductus arteriosus with a left-to-right shunt would give a similar dye curve.

Left-to-right shunts of less than 20% of pulmonary blood flow may not give a significantly abnormal dye curve when the injection is made proximal to the lungs and blood sampled from a peripheral artery (the so-called arterial dilution curves). Smaller left-to-right shunts, however, can be detected by injecting the dye in the left side of the heart and sampling selectively from the right side of the heart (the so-called venous dilution curves).

In right-to-left shunts, the indocyanine is

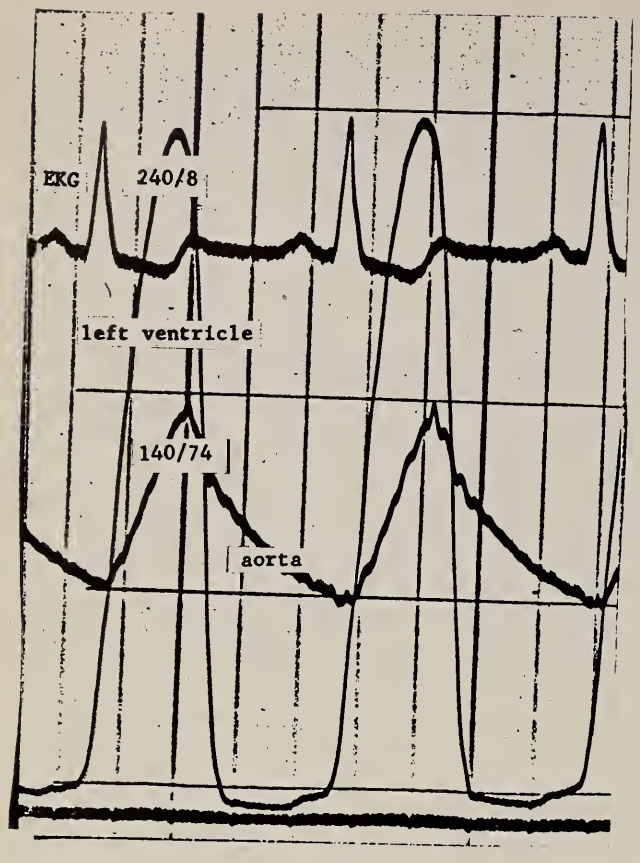



FIGURE 10
SIMULTANEOUS left ventricular and aortic pressure tracings from a patient with aortic stenosis. Note the systolic gradient of 100 mm. of Hg.

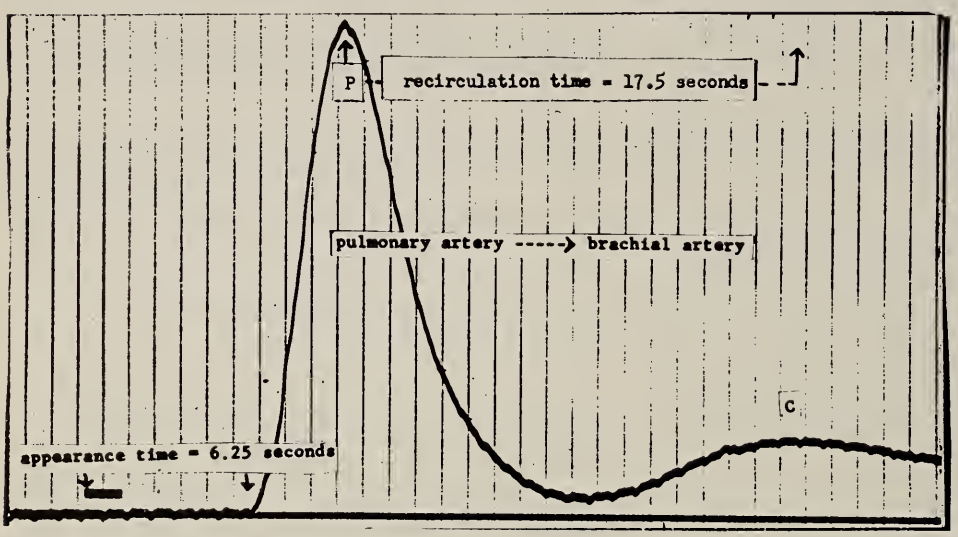



FIGURE 11
NORMAL dye-dilution curve.

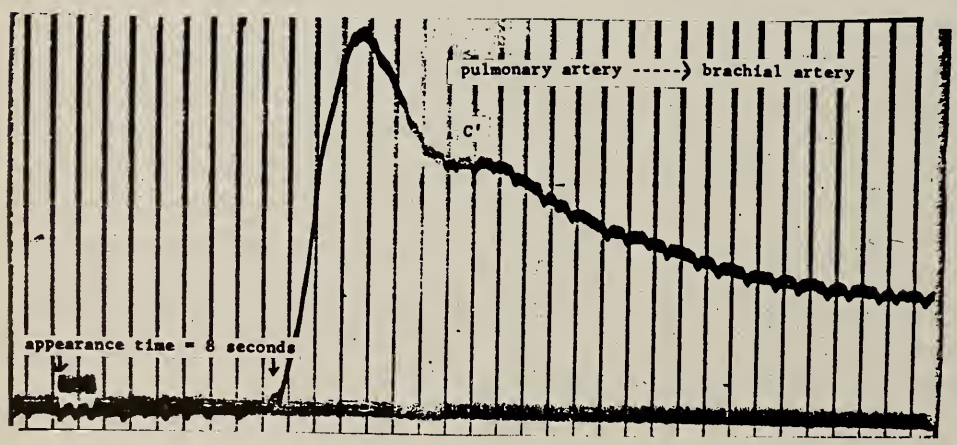



FIGURE 12
DYE-DILUTION CURVE from a patient with an atrial septal defect. The left-to-right shunt is demonstrated by early recirculation of dye (hump C').

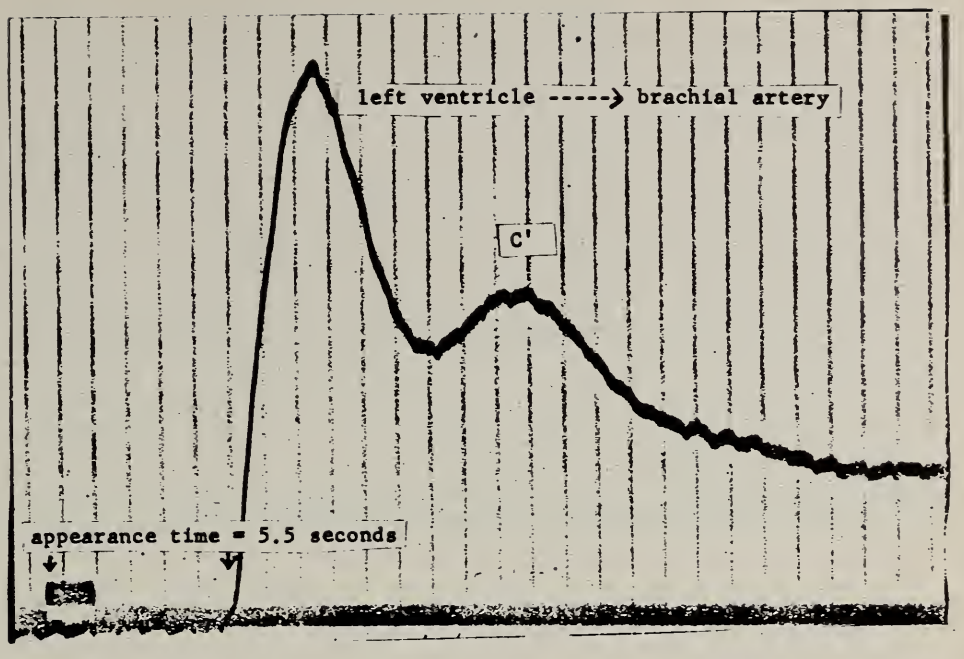



**FIGURE 13**
**DYE-DILUTION CURVE** from a patient with a ventricular septal defect. The left-to-right shunt is demonstrated by early recirculation of dye (hump C').

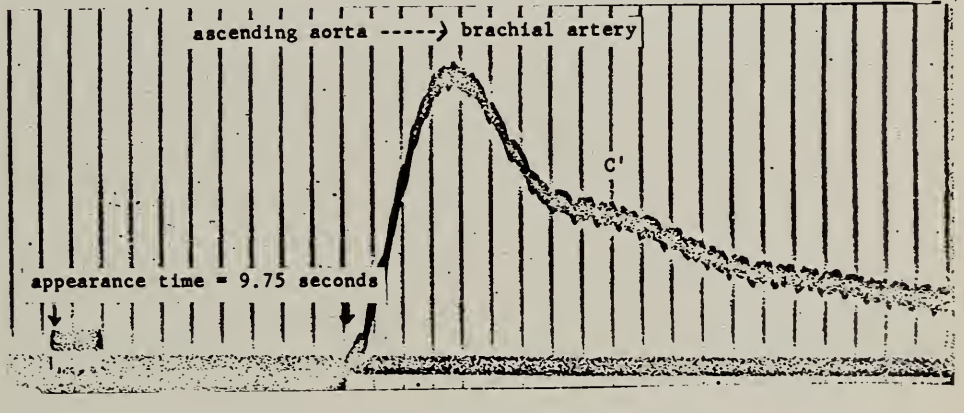



**FIGURE 14**
**DYE-DILUTION CURVE** from a patient with a sinus of Valsalva aneurysm that ruptured into the right atrium. The left-to-right shunt is demonstrated by the early recirculation of dye (hump C').

injected into the right atrium or right ventricle and sampled from the brachial artery. The shunted dye bypasses the lungs and appears at the brachial artery earlier than when injected into the pulmonary artery. Figure 15 shows two dye curves from the same patient. The top curve was made by injecting the dye into the pulmonary artery and sampling from the brachial artery. It is nearly a normal curve and the appearance time of 11 seconds is normal. The lower curve was made by injecting the dye into the right ventricle and sampling from the brachial artery. The appearance time is shortened to seven seconds indicating a right-to-left shunt. The first hump A represents the shunted dye appearing at the brachial artery early and the second hump B represents the unshunted blood appearing at the brachial artery. This patient had a cyanotic tetralogy of Fallot.

Selective cineangiography is usually the most useful method to evaluate an incompetent valve during cardiac catheterization; however, dye curves can sometimes be helpful in evaluating incompetent valves. The patient whose dye curve is shown in Figure 16 had a history of allergic reaction to IVP dye. We decided not to do cineangiograms because of the allergic history. It was pertinent for the disposition to know whether the patient had mitral insufficiency. The indocyanine dye was injected into the left ventricle and the blood sampled from the left atrium. Note the early appearance of dye in the left atrium at peak P. Peak P represents dye which regurgitated from the left ventricle to the left atrium across an incompetent mitral valve. Thus the presence of rather significant mitral insuffi-

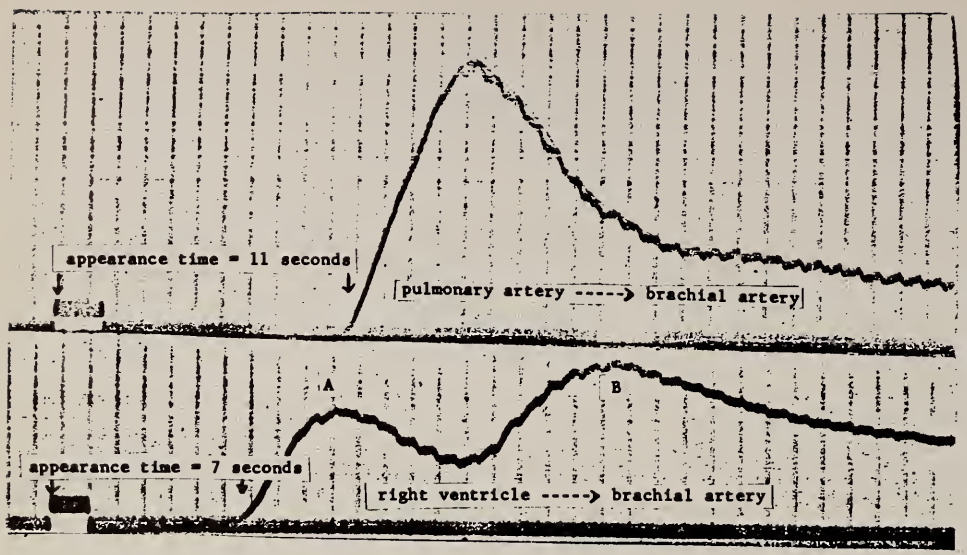



**FIGURE 15**
**DYE-DILUTION CURVE** from a patient with a cyanotic tetralogy of Fallot. The right-to-left shunt is demonstrated by the early appearance of dye when injected in the right ventricle.

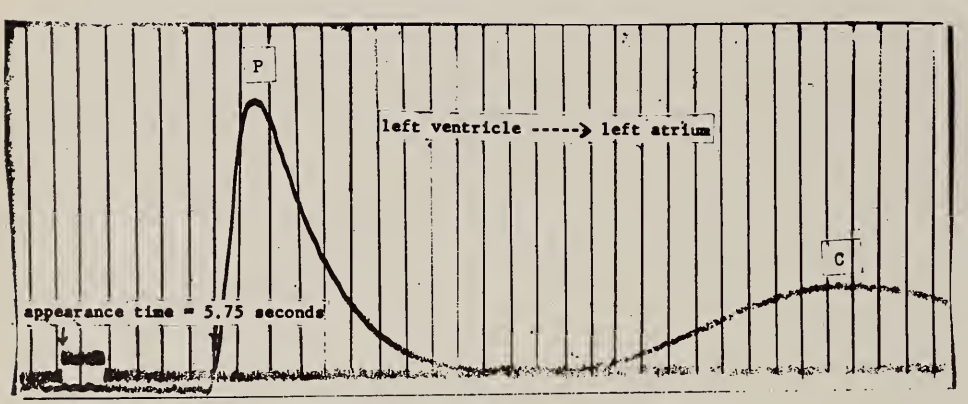



**FIGURE 16**
**DYE-DILUTION CURVE** from a patient with mitral insufficiency. The dye was injected in the left ventricle and sampled in the left atrium.

## HEMODYNAMIC VALUES FROM NORMAL SUBJECTS CATHETERIZED AT INDIANA UNIVERSITY MEDICAL CENTER

| | Cardiac Output (1/min.) | | Cardiac Index (1/min.) | | $O_2$ Consumption | Pulmonary Vascular Resistance | |
|---|---|---|---|---|---|---|---|
| | Fick | Dye-dilution | Fick | Dye-dilution | (ml./min.) | Units | (dynes/sec./cm$^{-5}$) |
| **RESTING** | | | | | | | |
| Indiana University Mean | 5.7 | 6.0 | 3.3 | 3.45 | 216 | 1.7 | 94 |
| Indiana University Range | 3.0-7.9 | 3.8-9.0 | 1.9-5.1 | 2.5-4.4 | 134-271 | 0.6-2.3 | 50-184 |
| **EXERCISE** | | | | | | | |
| Indiana University Mean | 8.45 | 9.6 | 4.7 | 5.35 | 545 | 1.3 | 105 |
| Indiana University Range | 6.8-10.2 | 5.7-15.7 | 3.9-5.6 | 3.7-7.6 | 316-1075 | 0.7-1.9 | 57-152 |

## CARDIAC CATHETERIZATION DATA OBTAINED AT INDIANA UNIVERSITY MEDICAL CENTER FROM NORMAL SUBJECTS*

| | Indiana University Mean | | | | | | Indiana University Range | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Resting | | | Exercise | | | Resting | | | Exercise | | |
| | S | D | M | S | D | M | S | D | M | S | D | M |
| Right atrium | 8 | 2 | 5 | 8.5 | 1.5 | 4 | 6-15 | 0-5 | 3-8 | 8-9 | 0-3 | --- |
| Right ventricle | 26 | 6 | 11 | 28 | 5.5 | 8 | 21-37 | 2-9 | 9-15 | 21-35 | 4-7 | 8 |
| Main pulmonary artery | 23 | 9 | 15 | 26 | 9 | 16.5 | 20-37 | 5-15 | 11-18 | 20-32 | 3-14 | 13-20 |
| Wedge | 14 | 5 | 9 | 16 | 9 | 12 | 9-17 | 0-7 | 5-12 | 16 | 9 | 12 |
| Left atrium | 14.5 | 4.5 | 9 | 17 | 7.5 | 11.5 | 13-16 | 2-6 | 8-11 | 16-18 | 5-10 | 11-12 |
| Left ventricle | 177 | 9 | 51 | 131 | 8 | 68 | 85-141 | 8-12 | 39-65 | 104-150 | 4-12 | 60-76 |
| Systemic artery | 122 | 72 | 93 | 136 | 80 | 105 | 89-150 | 54-97 | 69-117 | 107-170 | 70-94 | 80-140 |

| | Wade & Bishop[9] | | | | | | Fowler[10] | | | Luisada[8] | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Resting | | | Exercise | | | Resting | | | Resting | | |
| | S | D | M | S | D | M | S | D | M | S | D | M |
| Right atrium | --- | --- | --- | --- | --- | --- | --- | --- | 1-4.5 | --- | --- | 3.8 |
| Right ventricle | --- | --- | --- | --- | --- | --- | 19-31.5 | 2-6 | --- | 23.3 | 4.4 | --- |
| Main pulmonary artery | --- | --- | 8-21 | --- | --- | 20-30 | 16-29 | 5-13 | 10-18 | 21.1 | 9.2 | 14.5 |
| Wedge | --- | --- | 5-13 | --- | --- | 5-15 | --- | --- | 4.5-13 | --- | --- | 10 |
| Left atrium | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Left ventricle | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Systemic artery | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

* All pressures in the above chart are measured by mm. Hg.
S=Systolic pressure
D=Diastolic pressure
M=Mean pressure

ciency could be established. The second peak C represents the dye that has circulated normally through the systemic and pulmonary vascular beds as it appears in the left atrium.

Cineangiograms are also very helpful in locating extra and intracardiac shunts. It may be difficult to tell how much valvular insufficiency is present with pressure curves and selective cineangiograms may help to evaluate the degree of regurgitation. Cineangiograms are also helpful in studying stenotic valves, for valve motion and obstruction to flow can be visualized.

## Summary

In general, pressure curves are most helpful to evaluate stenotic valvular lesions and the functional capacity of the heart; cineangiograms are most helpful to evaluate valvular insufficiencies and shunts and dye curves are extremely helpful in evaluating shunts.

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**Due to a lack of space in this Heart Issue, the fourth "heart" paper, *The Phonocardiogram and External Pulse Tracings*, by Morton E. Tavel, M.D. and Charles Fisch, M.D., Indianapolis, will appear in the March issue of *The Journal*.**

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Direct Needle Puncture in the Diagnosis of Renal Mass Lesions in Infants

ERICH K. LANG, M.D.*
*Indianapolis*

A TWO-YEAR-OLD white male was admitted to Methodist Hospital because of hematuria of three days duration and a large mass palpable in the left abdomen. A few days prior to admission, he reputedly hurt his right side while playing. Physical examination revealed distention of the abdomen with dullness to percussion and a cyst-like mass on the left side. Urine analysis showed two to four white cells but no red cells. Hemoglobin was 14, the hematocrit 42, the white blood count 11,000 with a normal differential count.

A flat plate of the abdomen and an intravenous pyelogram were obtained and demonstrated a functioning but malrotated right kidney. Several of the lower calyces pointed toward medial and suggested the possibility of a horseshoe kidney. The most significant findings were limited to the lower portion of the right ureter at the point of crossing over the pelvic rim. The ureter was displaced laterally around what appeared to be an extraneous mass. None of the films, including a three hour delayed film, showed any function of the left kidney.

For a definite preoperative diagnosis, a needle aspiration of the suspected hydronephrotic left kidney was carried out. A #20 needle was introduced through the left flank and straw colored fluid was readily aspirated. Analysis showed this fluid to contain 380 mgs. % of urea. Approximately 40 ccs. of fluid were aspirated. An equal amount of 50% hypaque was used to replace the fluid. Subsequent roentgenograms revealed a huge hydronephrotic sac protruding across the midline to the right side. This protrusion caused the apparent displacement of the right ureter. A preoperative diagnosis of a hydronephrotic sac of the left kidney was made. A horseshoe kidney was suspected on the basis of the medial placement of the lower right calyceal group.

Transabdominal exploration revealed a huge, thin kidney which filled the entire left flank. The upper pole of the kidney was freed without difficulty; the lower part had to be freed by blunt and sharp dissection. Anomalous vessels appeared to supply the upper and the lower poles. It was felt that the hydronephrosis was due to a ureteropelvic junction obstruction. The lower pole of the left kidney was tilted medially and an isthmus of parenchyma bridged to the lower pole of the right kidney. The isthmus was clamped and divided without difficulty.

## Discussion

The preoperative diagnosis of hydronephrosis is often suggested on intravenous pyelograms. In contrast to other abdominal masses caused by tumors in an infant, hydronephrotic kidneys fail to show any dye excretion. Most tumors, even large ones, will show residual function and demonstrate a distorted and displaced pelvocalyceal sys-

* Department of Radiology, Methodist Hospital, Indianapolis.

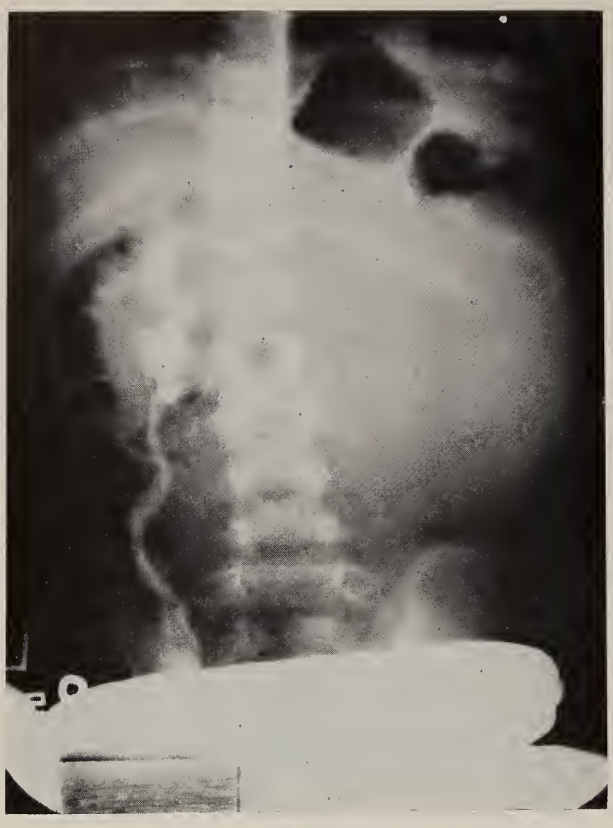


**FIGURE 1**

**NOTE THE huge mass in the left flank, displacing bowel shadows, crossing the midline and resulting in displacement of the lower part of the right ureter. Medial tilting of the lower calyceal group of the right kidney suggests the presence of a horseshoe kidney.**




**FIGURE 2**

**FORTY CCS. of fluid have been aspirated and replaced by 40 ccs of 50% hypaque. The huge hydronephrotic kidney pelvis with dilated calyces is readily delineated. The kidney pelvis is so large that it crosses the midline. Undoubtedly, the dilated kidney pelvis causes the displacement of the ureter demonstrated on the other film.**

tem. However, a definitive preoperative diagnosis can be made by needle puncture, aspiration and examination of the fluid and finally, direct radiographic demonstration of the kidney pelvis or cystic mass by introduction of air and contrast medium. The value of this procedure is particularly shown in cases of huge Wilm's tumors that may have secondarily resulted in a nonfunctioning hydronephrotic kidney. These tumors are best irradiated preoperatively to shrink the tumor mass and render it surgically resectable. Only the definitive preoperative diagnosis allows this type of determination and decision.

The procedure is felt to be quite safe and without complications. If a cystic area is not found by the probing needle, it can be assumed that one is dealing with a solid tumor. A very small amount of nitrogen mustard can be injected during the withdrawal of the needle to guarantee sterilization of any tumor cells that may have been implanted in the puncture canal. ◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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# A Ten-Dollar Cadillac

ROBERT COULSON*
*Member, Illinois Senate*

"THERE is no trick to this," said the man. "I'll sell you a brand new Cadillac, this year's model, for ten dollars. I'll sell you as many as you want. Or any other make of car on the same basis. Any color or model and I'll make the same offer next year when you wish to trade it in.

"For my profit," he continued, "all I want is a note for thirty thousand dollars payable 20 years from now, and signed by your relatives and neighbors."

My first reaction was suspicious refusal. It seemed that he was making too much profit. There was too great a difference between five thousand dollars advanced now and thirty thousand dollars repaid in 20 years. But then the gnawing doubt began to assail me.

I would not have to repay any of it. Perhaps my children and neighbors could easily afford the money when the debt came due. Perhaps none of them would be alive. Perhaps they will have moved away, and he cannot find them to serve the legal papers on them. Perhaps my grandchildren and neighbors can win the case in court 20 years from now. Perhaps there will be wild inflation then, and thirty thousand dollars will seem nothing. Perhaps this country will be conquered by another country, or become involved in a civil war and the debts will all be voided.

If any of these things happen; if there is any kind of inflation, repudiation, or invasion, then I could beat the game and have a Cadillac for ten dollars.

And even if none of those things happen within the 20 years, my grandchildren and the neighbors' grandchildren can refinance the note and promise to pay sixty thousand dollars in 20 more years and they can wait for the inflation, repudiation or invasion.

There is a great temptation to gamble on the hope that Something Will Happen. Meanwhile, the Cadillac would be mine to enjoy. So I selected a white convertible, paid the ten dollars, and drove happily away.

But how did that huckster and I manage to get my relatives and friends to sign

* The Honorable Robert Coulson is a former Mayor of Waukegan, Illinois, now a member of the Illinois State Senate, a lawyer and banker and occasional contributor to magazines.

those notes? Easy! We cut them in on the same deal. And to salve their consciences, we put cars at the bottom of the list and offered them education, medical care and similar goods and services that they desperately needed. We had no trouble at all in getting them to vote on the scheme and turn the whole thing over to our government officials to handle for us. After all, isn't that why we elect them?

So I am driving a white Cadillac. My elderly neighbors across the street are receiving their monthly checks from Washington. My neighbor's children next door are all in college at little cost to the parents. The other next-door-neighbor gets food coupons, plus a check from his government for not working.

And so on.

I expect that I will be dead before it is time to pay the piper. My grandchildren? Well, surely they will be at least as smart as I am. All they need do to beat the game in their time is to repudiate the debt, inflate the currency, or (if they are not too smart) refinance the national debt.

You know, sometimes I suspect that something is wrong with this whole scheme of more benefits from Washington at no cost except an increase in the national promise to pay in the distant future. But I don't seem to be able to explain it—even to myself; after all, I *am* driving that white convertible.—Reprinted from *Michigan Medicine* 63:12, December, 1964.

## Deaths Due to Car Driveway Accidents

Car driveway accidents occur with increasing frequency, especially in our burgeoning suburbs. Usually these types of accidents involve small children who are seriously injured, usually fatally, when struck down by motorists who back their cars out of driveways. Often the driver does not look into the rear view mirror of his car to see if the way is clear. Frequently the child is too small to be seen in the rear view mirror by the driver.

Prompted by the death of a child as the result of a car driveway accident, the authors undertook a survey of 12 northwest suburban communities of Chicago for 1963 and 1964 to determine the number of children injured or killed in this type of mishap. During this period nine children were fatally injured. The ages of the children ranged from 13 months to nine years, most of the children being under four years of age. A survey taken with the cooperation of the Cook County Traffic Safety Commission was helpful in compiling the death total. It is interesting to note that the accidents occurred in the newer suburbs. Older suburban communities such as Evanston, Skokie and Niles reported no fatalities or injuries.

A national survey taken by the National Safety Council showed that 300 children were fatally injured in 1963 as a result of vehicle accidents on home property. The great majority of these was due to driveway accidents involving the backing out of cars.*

It is difficult to estimate the frequency of this type of accident, since a separate classification is not always kept by the police and other accident prevention agencies. There is probably a larger number of fatalities than these figures indicate. The statistics do not take into account the significant number of seriously injured children. There is undoubtedly a great potentiality for the occurrence of this type of accident if the large number of bicycles and tricycles struck by motorists backing out of driveways is taken into account.

The following recommendations are suggested to prevent car driveway accidents:

- Doctors, as well as other drivers who make home visits, should be constantly on the alert for this ever present danger.
- A statewide or nation wide campaign should be instituted to alert parents to the danger of car driveway accidents and to the hazard of allowing small children to play on driveways behind parked cars.
- Specific safety precautions involving the parking of cars in driveways are sug-

* *Children in the Driveway*, Family Safety, Publication of the National Safety Council, Chicago, Illinois, p. 11, Spring, 1964.

gested: The question of parking cars so that the front end of the automobile faces the street should be considered. Most of the driveway accidents occur when the automobile is backed out and very few occur when the car is guided into the driveway. It is much easier to see a small child over the sloping hood of a car, than by looking behind the trunk of a car.

- Parents must educate their children to keep bicycles, tricycles and gocarts off the driveways and particularly not behind parked cars.
- Circular or angled driveways should be considered in building homes. This would allow the motorist to observe any child behind his car as he walks to it.
- A car should be parked so that its back end is fairly close to the street, leaving little space, which would discourage a toddler from playing behind the vehicle.
- If the rear end of the car cannot be seen as the driver leaves a home, he should circle his car before entering it.
- Parents should keep the doors of the car closed so children cannot enter. The car should be in parking gear and keys should never be left in the ignition. This may prevent children from precipitating car driving accidents.—Harvey Kravitz, M.D., Alvin Korach, M.D., reprinted from the *Illinois Medical Journal* 126:6, December, 1964.

## Editorial Notes...

**Blood Banks are inspected for accreditation by the American Association of Blood Banks.** Seven hundred and seventy-nine community and hospital blood banks are now accredited. Most of them are located in the continental United States, 13 are in Indiana. Inspecting is done by one of a team of 179 physicians, all of whom volunteer their time, including necessary travel, as a public service. Blood banks are applying for inspection and accreditation at such a rate as to make mandatory inspections, as proposed by some, very probably unnecessary.

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**The AAPS Newsletter points out that the largest single voting group in the U. S. is that composed of 26 million conservatives.** This group was defeated in the last election by a coalition of numerous power-seeking minorities, no one of which can come near to matching the size of the conservative vote. The point is that concerted action by the 26 million will most certainly have an effect on Congress. Congressmen listen to large numbers who are in agreement. So—*Start Talking.*

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**The Nuclear Ship Savannah, the world's first nuclear-powered cargo-passenger ship, may soon be operated by the Maritime Administration under a special license by the Atomic Energy Commission.** The ship has just completed her fourth foreign voyage of 1964 and the investigative and exploratory aspects of her operation are considered finished. More than a million persons have visited the ship during the time she has traveled more than 75,000 miles.

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**Prof. Ulrich Clever of Purdue University recently described the first steps in the chain of chemical action by which genes control the life of the cell.** He studied the insect Chironomus tetans, a small midge whose chromosomes are gigantic in relation to other forms of life. The midge's chromosomes are ten thousand times thicker and ten times longer than ordinary. The genes are visible under any standard microscope and changes in them due to hormonal stimulation may be observed. Prof. Clever has been able to demonstrate that a specific ribonucleic acid is manufactured by certain genes when certain enzymes are exhibited; other biologic substances will delay or inhibit the process.

---

**Women are aging less in modern times.** An editorial in the *JAMA* points out that the median age of menopause in Great Britain for the decade before 1961 was 50.1 years. This is an increase in the age of menopause of about four years during the past century. Moreover, ancient literature indicates that 40 was the mean age of the climacteric several centuries ago. This, combined with an earlier menarche, would tend

to indicate that women are enjoying a decreased rate of physiological degeneration.

**More auto drivers between the ages of 15 and 24 lose their lives while driving than do drivers in any older decade of life.** The rate is 40.4 per 100,000 population, and since 1961 the rate has been increasing. The Metropolitan Life Insurance Company points out that the absolute figures are going to increase with the steady increase in the number of adolescents and young adults in the U. S. The great majority of deaths occur in cars which collide with other cars, strike a fixed object or overturn. The auto toll accounts for almost two fifths of the total mortality in this age bracket. The life insurance company says something should be done about it.

**The new National Formulary, twelfth edition, to be published in 1965, is the first edition of this work to include drugs solely on the basis of their "therapeutic merit."** Formerly "extent of use" was the basis for inclusion. More than one-third of the entries in the eleventh edition will not appear in the twelfth; 248 of the 783 monographs in the new edition will be new entries.

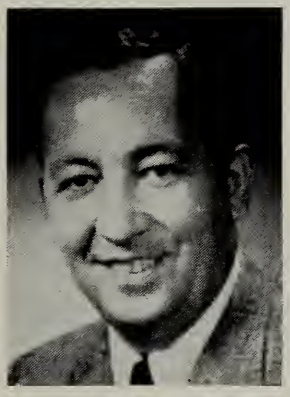
**Dr. Ian Macdonald, editor of the Los Angeles County Medical Association, has compared the efficiency and effectiveness of a private hospital and the VA hospital in Fresno County, California.** The Fresno Community Hospital has 299 beds, the VA hospital 250. If the Community Hospital cared for patients in as leisurely a fashion as the VA facility, and kept each patient in the hospital as long, the Community Hospital would have to have 1,088 beds to care for as many patients as it does. If all four private hospitals in Fresno County operated on the level of the VA hospital, a total of 1,073 more private beds would be required and some $16 million or $17 million more would be needed for their operation. Better send this information to your Congressman.

**Fetal malformation is induced in the very early stages of pregnancy.** Recent experience with thalidomide has proven how little is known of the relation of drugs and embryonic abnormalities. Since the teratogenic effect of any harmful agent, including possibly some drugs, is active before the patient knows she is pregnant, chemotherapeutic nihilism is recommended for women in the child-bearing ages. Self-medication by the same group is likewise discouraged. Pending further knowledge, it would be better if women in the child-bearing age could get along without any drugs.

**The death rate from cancer in women in the U. S. has decreased by eight percent in the past ten years.** This rate is a composite of percentage decreases in mortality in specific malignancies as follows: stomach 37, intestines 6, rectum 22, liver 31, uterus 27, urinary organs, 11. Percentage increases were for pancreas 12, lungs 25, ovary 7, brain 17, and Hodgkin's, 8. The mortality rate for breast cancer is unchanged, not only in the most recent decade, but also in the two decades before that. The Metropolitan Life Insurance statisticians who announced the data think that some of the variations are due to more exact diagnoses and that the improvement is due to earlier discovery and treatment. ◄

# President's Page

"Hoosier Hysteria" is a compound proposition every other year. This year the biennial General Assembly competes with "Hoosier Hoopla" for the headlines in discussions of the proper execution of various maneuvers.



Medicine annually has over 100 bills introduced which affect the practice of medicine in some form or another. This year the "ball" is bouncing rapidly. It is always interesting to observe what groups or organizations are interested in the practice of medicine, medical education and its ancillary fields.

This year legislation has been proposed in regard to liberalization of medical licensure, the "battered child," more medical schools, a Board of Certification for Psychologists, protection for our own investigative committees and commissions and PKU diagnosis.

Your Commission on Legislation is working very hard for the next two months to screen, advise and recommend to your legislators and your officers. Their job is long, arduous and complex and I appreciate their efforts. If you have thoughts pertinent to present legislation, contact a member of the commission. They always appreciate your suggestions.

It has been my pleasure, as president, to attend several functions of state groups and various county societies and I certainly wish to thank all those who were involved for their courtesies and kindnesses to my wife and myself.



# The Woman's Auxiliary

## REPORTS TO ISMA

The objects of the Woman's Auxiliary to the Indiana State Medical Association are:

(1) To unite in one organization the wives of the members of the Indiana State Medical Association;



(2) To assist the Indiana State Medical Association in its program for the advancement of medicine and public health;

(3) To participate in any endeavor, on request of the Indiana State Medical Association;

(4) To coordinate and advise concerning the activities of constituent auxiliaries;

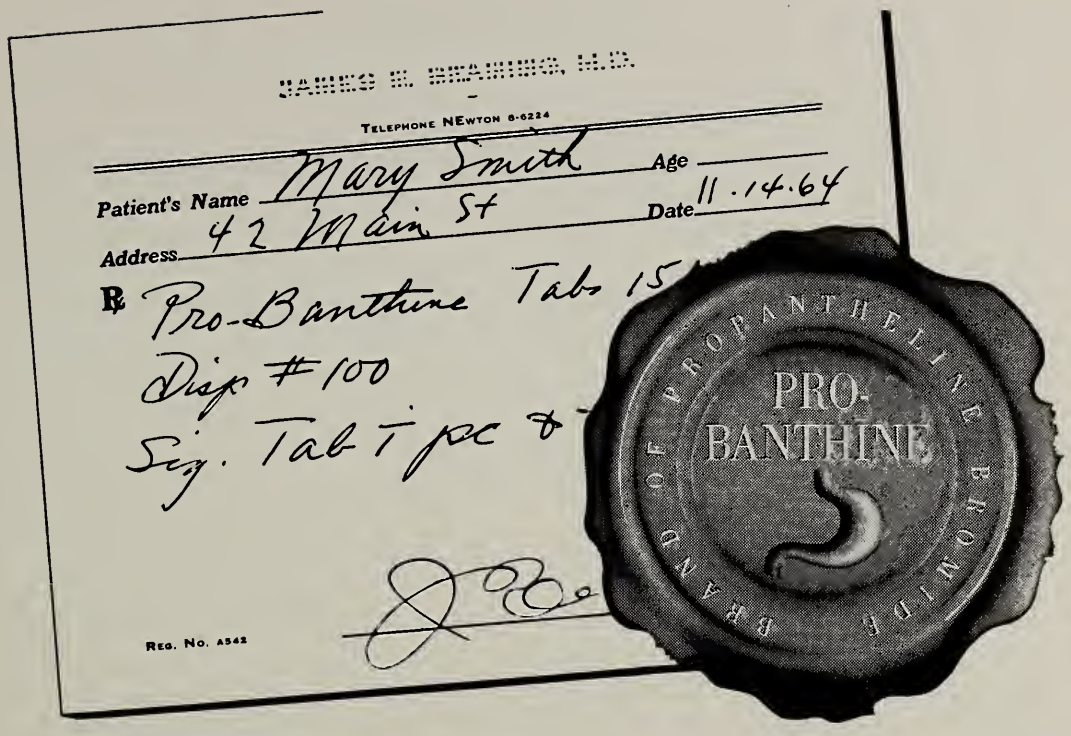
(5) To cultivate friendly relations and promote mutual understanding among physicians' families.

We have 60 county auxiliaries representing 71 counties and 65 members-at-large with a total membership of 2,828. Our basic programs are: AMA-ERF, Community Service, Disaster Preparedness, Health Careers, International Health Activities, Legislation, Medical Care Insurance, Mental Health, Rural Health and Safety. Each county auxiliary participates in all or part of these programs.

Through the auxiliary we gain information and determine how to best meet community needs. Our members give thousands of hours annually working in community service. Last year's AMA-ERF contribution was $16,125; health career scholarships, $10,745; and student loans, $3,500.

County auxiliaries welcome the advice and counsel of their county medical societies. Impressive statistics are the result of local work. We hope to have an even better report this year as we continue to work for "Better Health in a Better World."

Bea Shields




# Stamp of Approval on Virtually any Ulcer Regimen-

# PRO-BANTHĪNE®

## (propantheline bromide)

Historically, reduction of acid and motility in peptic ulcer has been approached through the use of antacids, dietary management and surgery.

Since 1953, however, Pro-Banthīne used alone or in addition to other measures has contributed importantly to achieving both of these goals. It has been shown repeatedly that adequate doses of Pro-Banthīne will significantly inhibit gastric acid secretion and reduce gastrointestinal motility.

So dependable have these actions been that now, for many, standard treatment of peptic ulcer and several allied conditions has become antacids *plus* Pro-Banthīne, dietary management *plus* Pro-Banthīne, surgery *plus* Pro-Banthīne, or some combination of the three.

Pro-Banthīne has become the most widely prescribed anticholinergic for patients with peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia because patients respond favorably to its therapeutic actions.

**Side Effects and Precautions**—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

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*Research in the Service of Medicine*

# The Student American Medical Association in Indiana*

FRANK JOHNSON, JR.**
*Indianapolis*

LIKE MOST THINGS in medicine, our activities may be classified into several major categories. Those based on concept and future goals provide opportunities for the enrichment of medical training through the experience of both scientific and non-scientific activities. Those involving the advancement of the profession of medicine are concerned with the preparation of a student to meet the social, moral, and ethical obligations of the profession of medicine.

As you know, our organization parallels your organization in many ways. However, there are some very important differences. This was intended since our founding—we are a service organization. As Dr. Joseph P. Garland, past editor of the *New England Journal of Medicine,* said "The generation in action can only implore the one in training to guard the freedom of the future and to perpetrate as few as may be of errors of the past."

It is a charge on today's leaders that the younger men who accept their guidance shall be left free to develop their own opinions and shall be protected against the risk of being sucked into any creed of unrevised traditionalism. This right to choose our activities and direction has laid a great responsibility upon us, and it is to this—the execution of this right and the fulfillment of this great responsibility—that we direct our energies.

Our organization is a service organization for the student. It serves him in many ways. Probably the most important of these is to acquaint the student with so-called organized medicine; more specifically with the machinery and mechanics which have provided the best medicine for the American people and the best doctors and working conditions in the world.

However, to represent an idea and speak in unity, there must be a declaration of purpose. This declaration is initiated in the membership. We have approximately 650 SAMA members; about 80% of our student body are voluntary members. We are classified among the top five chapters in the country and we are the largest chapter of all the medical schools. We take pride in this accomplishment for this alone makes us the largest student chapter, and the largest student medical organization in the world. If you feel that we are tooting our own horn, you're probably right for though the doctor should work in humility, he should protect the right to do so.

However, size alone is not enough, so here are a few of the things that we are doing. We assist the schools with freshman orientation and provide the freshmen with a free breakfast at the beginning of school, and a wholesome atmosphere to allow an opportunity for the freshmen to meet as many as possible of the faculty on an informal basis. We assist the dean's office in several ways. For example, with the Scout program, the Alumni Day program and the touring service.

We conduct a counseling service program for high schools. This provides them with information on medicine as a career and is a free service to any high school in the state. Noon movies are shown, twice per week, on medical subjects involving diagnosis, treatment and legal medicine. We are cooperating with the Dean's office in inviting noted speakers in the field of medicine to our campus. We invite competition. Each year we enter several of the major contests that are offered by the various companies across the country. And may I tell you that only last year, of 12 top awards, our chapter won five, though there are some 70 other chapters in the country.

---

* Report presented to the House of Delegates, Indiana State Medical Association annual convention, Oct. 12, 1964.

** President of the Indiana Chapter of the Student AMA, I. U. School of Medicine, Indianapolis.

Each year SAMA selects the best clinical professor and the best non-clinical professor of the year. These outstanding men are honored at a banquet. At this time they receive a plaque signifying their appreciated service. Probably the most important function and activity we have is to keep the student abreast of changing trends, both in medicine and those which have a direct relationship to medicine.

We are conscious of the importance of being well trained, but we cannot deny ourselves the opportunity to execute this training in the best interests of the people we serve, be it medicare or Social Security. You have obtained and preserved for us the best system of medicine in the world. If this heritage should live and grow, we cannot accept it unprepared. In this vein, we eagerly accept the invitation of your official committees to attend their meetings as ex-officio members and learn of medicine's problems.

In summation, our activities provide the learning experiences for the student which we hope will equip him to inherit and safeguard your and our most sacred possession, the practice of medicine. ◄


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*Interpreted by*
*ROBERT HOLLOWELL, LL.B., legal counsel*
*Indianapolis*

Every other year, preceding the convening of the legislature, someone comes forth with suggestions as to the qualifications of county coroners. Over the years, numerous suggestions have been made relative to qualifications that a coroner should be required to have. Many of these suggestions have been well taken and consistent with the duties which a coroner, by law, is required to perform.

However, we are always confronted with the proposition that the office of coroner is a constitutional office. It is created as a county office by Sec. 2 of Article VI of the Constitution of Indiana. Sec. 4 of Article VI provides the qualifications of county officers, the only qualification of a county officer being that he shall be an elector of the county and an inhabitant thereof during one year next preceding his appointment.

There is a long and well established rule of constitutional law in this state that where the Constitution prescribes qualification for a constitutional office, the legislature cannot prescribe additional qualifications.

A similar situation exists in the legal field relative to a justice of the peace, which is also a constitutional office. It has long been felt that a justice of the peace should be required to have some legal training or experience as a qualification for his office. In 1957, the legislature passed an act establishing qualifications for the office of justice of the peace and providing that he be either an attorney in good standing or have completed one full term of office as a justice of the peace after January 1, 1948, or have received a passing grade in an examination approved by the Supreme Court of Indiana.

The constitutionality of the legislation imposing these qualifications for such office came before the Indiana Supreme Court and the Supreme Court held that it was beyond the constitutional power of the legislature to provide qualifications for the office of the justice of the peace, in addition to those which were prescribed by the Constitution of Indiana. The opinion of the court was given in the case of *In re Petition of Justice of the Peace Association of Indiana*, 237 Ind. 436. The court, in its opinion, at page 440, said:

> "This court has recognized the rule that where the Constitution prescribes qualifications for constitutional officers, the General Assembly cannot prescribe additional qualifications. 'The General Assembly cannot impose qualifications upon officers beyond those prescribed by the Constitution. *State, ex rel.* v. *McAllister* (1893), 38 W. Va. 485, 489, 18 S. E. 770, 24 L. R. A. 343, 345; *Darrow* v. *People* (1885), 8 Colo. 417, 420, 8 Pac. 661; *State, ex rel.* v. *Covington* (1876), 29 Ohio St. 102, 117; *Mason* v. *State, ex rel.* (1898), 58 Ohio St. 30, 54, 50 N. E. 6, 41 L. R. A. 291; *People, ex rel., v. May* (1855), 3 Mich. 598; *Attorney-General* v. *Abbott* (1899), 121 Mich. 540, 546, 80 N. W. 372; *State, ex rel. v. Dunn* (1875), 73 N. C. 595, 606; *State, ex rel.*, v. *Woodson* (1867), 41 Mo. 227, 230; *State, ex rel.* v. *McSpaden* (1897), 137 Mo. 628, 635, 39 S. W. 81; *State, ex rel.*, v. *Von Baumbach* (1860), 12 Wis. *310, *312; *Fordyce v. State, ex rel.* (1902), 115 Wis. 608, 614, 92 N. W. 430; *Territory, ex rel.* v. *Stubblefield* (1897), 5 Okla. 310, 319, 48 Pac. 112; *Sheehan* v. *Scott*

(1905), 145 Cal. 684, 79 Pac. 350, 351; *State, ex rel.*, v. *Dillon* (1893), 32 Fla. 545, 569, 14 South. 383, 22 L. R. A. 124; *State, ex rel.* v. *Bryan* (1905), 50 Fla. 293, 376, 39 South. 929; *State, ex rel.* v. *Huegle* (1907), 135 Iowa 100, 101, 112 N. W. 234; *Shaw* v. *City Council, etc.* (1906), 131 Iowa 128, 104 N. W. 1121, 10 L. R. A. (N. S.) 825, 829.' *State ex rel. Workman* v. *Goldthait* (1909), 172 Ind. 210, 218, 219, 87 N. E. 133."

Under this decision and the many decisions cited by the court as set forth in the above quotation, there seems to be no question about the fact that the legislature cannot constitutionally impose additional qualifications to hold the office of county coroner, other than that he be an elector of the county and have been an inhabitant thereof during one year next preceding his appointment.

This would leave only two solutions. One would be to repeal the constitutional provision relative to coroners or to amend it to permit the legislature to fix qualifications for eligibility to the office. The other solution would be to create a new statutory office under another name, such as "medical examiner," and transfer most of the duties now imposed by statute upon the coroner to the new office. This latter is objectionable as it would then leave in existence an office and officers with little or no duties or functions to perform, although this has been done to a considerable extent in connection with the office of township trustee. The problem of a constitutional change is that it would involve a minimum of six (6) years' time to accomplish. ◄

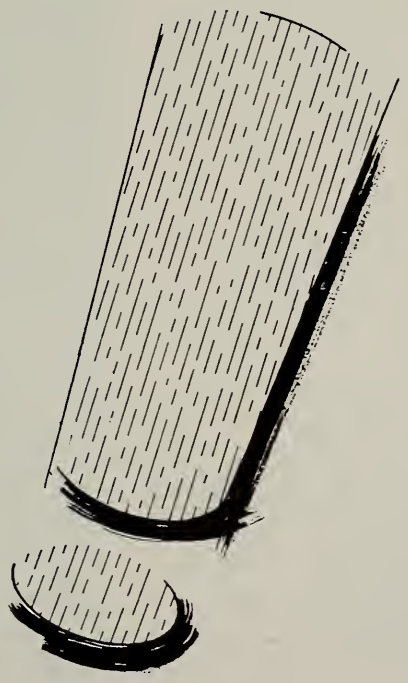

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# DAY BY DAY WITH THE F D A

**From the FDA Reports on Enforcement and Compliance.**

No one in the FDA laughed very much when attention was called to a page of gag instructions in the magazine *Escapade* for August, 1964. Labeled later by its editor as an intended joke was the statement on page 15 that the ink used in printing the entire magazine had been mixed with some powerful hallucinogenic agent and that to obtain the effects, two pages of that issue could be dissolved in methyl alcohol and taken by mouth. FDA warnings were issued to counteract the "joke."

* * *

The price of safety is vigilance. A batch of imitation black walnut flavoring was discovered in Kansas City and destroyed because it contained coumarin. The FDA report includes a phrase which is certain to be the prime understatement of the season —"coumarin—nonpermitted ingredient."

* * *

Several new "wrinkle removers" distributed by at least three different companies have been declared and defined as drugs because the intended effect is to cause a change in the skin. Accompanying literature was objected to because of implications that the effect was more than temporary in nature, whereas in fact FDA found the remedies to be strictly temporary in action. Sponsors of the products were notified that new drug applications should be filed for the "wrinkle removers" and that sale of the "cosmetic" would be legal only when, as and if, the drug was approved.

* * *

A pharmaceutical manufacturing concern was discovered housed in an old chemical plant on a dirt road in New Jersey, stocked with quantities of basic ingredients for making meprobamate and over a ton of meprobamate powder. A court injunction was obtained on the grounds that the company was not registered with the FDA as a pharmaceutical manufacturer, did not have a new drug application for interstate shipment of meprobamate and had initially refused to permit inspection of its premises as required by law. This is how to go out of "business" without really trying.

* * *

The FDA has objected to two products of the Carnation Company, Instant Breakfast and Ease Instant Syrup, both of which contain a reduced quota of nutritive sugar together with an artificial sweetener, sodium cyclamate and sodium saccharin. In so doing it was pointed out that the several artificially sweetened syrups on the market are not objectionable since they are so labeled and since they do not contain real sugar. The label with its standard statement "should be used only by persons who must restrict their intake of ordinary sweets" was classified as misleading.

* * *

Compressed tablets bear identifying punch marks which, when studied microscopically, make it possible to determine the manufacturer. The science of "pillistics" has developed remarkably since the FDA has been interested in detecting and controlling counterfeit drugs. Detailed examination of the exterior of a pill and a study of the crystalline compounds it contains is about as reliable as the science of ballistics and almost as exact as the study of fingerprints. Capsules are less susceptible to identification since the external surface is more apt to be uniform.

The illegal sale of prescription drugs constitutes the largest block of serious and deliberate offenses the FDA uncovers each year. There have been over 2,100 convictions in 12 years for illegal sales of amphetamine and barbiturates. The viciousness of the traffic is sufficient to inaugurate special training in self-protection for agents assigned to undercover investigations. Amphetamine can be purchased wholesale for $1.00 per thousand and retails at 5 to 10 cents each.

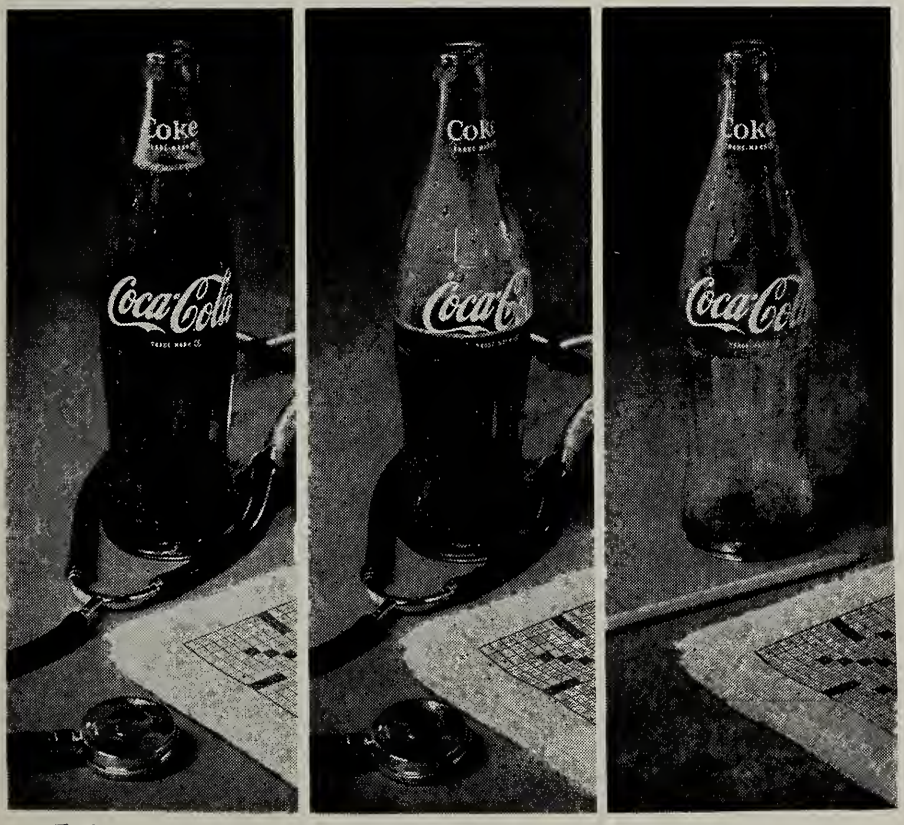
* * *

New labeling regulations have been issued for phenacetin. A special committee has reported that there is evidence that the misuse of phenacetin probably causes kidney damage. Since phenacetin and some mixtures containing phenacetin may be sold without prescriptions, labels in the future will warn against overuse either by overdose or by prolonged usage. Children under the age of three years should never receive it.

The heaviest fine of the period, $5,000 plus court costs, went to a non-Hoosier physician who was convicted of selling drugs containing amphetamine, thyroid extract and phenobarbital. A significant part of the findings was that the drugs were furnished without the physician having performed a physical examination of the "patients."

* * *

"X-33", an extremely dangerous water repellant, is thought to be scattered over the U. S., in stores and possibly in possession of potential users. It is highly explosive and has caused three deaths and many serious injuries. The type first sold had a flash point of 40 degrees below zero. Later a type was made with a flash point of 73 degrees above zero. Both products bear the same label. No warning of the hazard is on either product. Anyone who knows of any cans of "X-33" is requested to acquaint the owner with the danger and advise that the nearest fire department be consulted as to safe methods for destroying the material. ◄


The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say **things go better with Coke**
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*Medicine At Law*

# DECISIONS AND OPINIONS

**Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.**

*Employee's Complaint States Cause of Action Against Employer's Doctor Despite Absence of Doctor-Patient Relation*—An employee's complaint stated a cause of action for damages against his employer's doctor for injuries allegedly caused by statements made to the employee by the doctor in connection with an x-ray the doctor took of his chest as part of his duties on the employer's behalf, even though there was no contractual doctor-patient relation between them, the Court of Appeals of Maryland ruled.

After taking the chest x-ray, which the employee was required to have taken annually because of the nature of his employment, the doctor allegedly told the employee that he had a little infection on his lungs and referred him to a consultant. It was alleged that, although the x-ray taken by the consultant clearly disclosed to the doctor that the employee had silicosis, he affirmatively misrepresented the employee's condition to him by permitting him to return to work in the same injurious environment and concealed from him the consultant's recommendation that he not be allowed to return to such work. The employee claimed that, as the result of this alleged breach of the doctor's professional duty to him, his lung condition has now become a permanent and serious disease.

Ordinarily, there can be a recovery against a doctor for malpractice only where there is a doctor-patient relationship which has resulted from a contract, express or implied, the court said. It has been held that there is no doctor-patient relationship between a prospective or actual insured and the doctor who examines him for the insurer, or between a prospective or actual employee and the doctor who examines him for the employer. If the doctor had done no more than take the x-ray, his only duty would have been to the employer.

However, a doctor may incur a tort liability that is nonconsensual and independent of contract. If a doctor gratuitously undertakes to render services which he should recognize as necessary to another's bodily safety, and leads the other person in reasonable reliance on the services to refrain from taking other protective steps, or to enter on a dangerous course of conduct, he is liable to the other person for bodily harm caused by his failure to use reasonable care in carrying out his undertaking. It was alleged that the doctor did more than take the x-ray. The allegations of what the doctor did would, if proved, constitute a cause of action against him, the court said.

*Hoover v. Williamson,* 203 A.2d 861 (Md., Oct. 13, 1964).

*No Liability Following Removal of Eye Tumor*—A jury exonerated a physician in a $50,000 damage suit arising from the removal of a tumor from the eye of an 11-year-old boy. The boy suffered from a drooping eyelid and double vision after the operation. In behalf of the physician it was argued that it was better to remove the tumor, which might have proved to be cancerous, even though it actually was not.

*Schultz v. Schall,* Cir. Ct., Cook Co., Docket No. 57S-19662 (Ill., June 25, 1964).

*Use of "One Time" Needle Invalidates Test Result*—The results of a chemical test for intoxication were improperly admitted in evidence in a prosecution against a driver on a charge of driving while intoxicated, where the statutory requirement that

the needle used in taking the blood sample be sterilized had not been complied with, the Supreme Court of Appeals of Virginia ruled.

The driver consented to a blood-alcohol test after his arrest on a charge of driving while intoxicated. The sample of his blood was taken by a registered professional nurse, a person authorized to do so under the State's "implied consent" law. A test of the sample disclosed the presence of 0.29% alcohol.

The nurse testified that prior to taking the sample she sterilized the driver's arm with Zephiran chloride solution but that she did not sterilize the needle with any substance. She stated that she used a presealed, disposable container, which was sterilized at the factory and which was used one time and then discarded. However, on cross-examination she admitted that she had never been to the factory where the needles were packaged and that she did not know if they were sterilized.

The driver contended that the test results should not have been admitted in evidence because the nurse had not, as required by the statute, sterilized the needle prior to taking the sample. The prosecution argued that in the absence of evidence to the contrary, it should be presumed that all of the statutory requirements with respect to the taking of a blood sample had been complied with.

The statute provides that if every part of the statute's provisions relating to the taking of a blood sample are not strictly complied with, the driver shall be found not guilty of any offense under the statute. It was obvious from the nurse's testimony that neither she nor anybody else at the hospital complied with the statutory requirement of sterilizing the needle before it was used to take the sample from the driver, the court said. She did not know whether the needle had been sterilized at the factory and it could not be presumed that it had been. Therefore, the judgment of conviction must be reversed and the case dismissed, the court ruled.

*Kyhl v. Commonwealth of Virginia*, 135 S.E. 2d 768 (Va., April 27, 1964).

*Substantial Settlement in Suit for Patient's Death Due to Doctor's Failure to Remove Gauze Pad*—A malpractice suit against a doctor for damages for the death of a 48-year-old male patient, in which it was alleged that the patient's death was caused by the doctor's negligence in leaving a gauze pad with a metal ring attached in the patient's body following an appendectomy, has been settled for $72,500. The suit, as originally filed, had also sought to recover damages from the Pennsylvania hospital in which the appendectomy was performed. The hospital was dismissed as a party because of Pennsylvania's continued adherence to the doctrine of charitable immunity.

*Medical Society's Tax-exempt Status in Question in Estate Tax Proceeding*—A Denver physician who died in 1958 established, by his will, a $675,000 trust fund and named the Denver Medical Society as one of four equal beneficiaries of the income from the trust fund. The Internal Revenue Service assessed an estate tax of $40,000 against the trust fund.

It is the position of the Internal Revenue Service that the trust was liable for the tax because the Denver Medical Society is not a non-profit organization "operated solely for religious, charitable, scientific, literary or educational purposes," and that the society is a lobbying group.

The society contends that it operates solely for tax-exempt purposes, that no part of its income goes to any individual member, and that no substantial part of its activities is devoted to a campaign to influence legislation. The society's 1963 financial report showed expenditures of $64,472, of which $430.71 was spent on "public relations" and $7,765 on a monthly bulletin which is circulated primarily to members.

The trust's attorneys paid the tax assessed, but have brought suit to recover it, plus statutory penalties. A decision is being awaited in a similar case, which has been tried, involving a bequest to the St. Louis Medical Society. ◄

# Blue Shield Provides for the Elderly

*(One of a series prepared by Blue Shield)*

Those who deride or ignore the efforts of voluntary health insurance plans in providing protection for those over 65 refuse to look at the facts. A look at the efforts of Blue Shield in providing such protection is most enlightening.

Blue Shield membership nationally now includes more than four million persons past 65, better than eight percent of the entire Blue Shield membership. In 1951, one million people, or five percent of Blue Shield's entire membership, were over 65.

Today enrollment in Indiana of persons 65 and over has reached a record high of more than 163,000 men and women, representing about 35% of our aged population.

It is particularly significant that while national Blue Shield membership during the 18 months ending last December 31 increased approximately five and one half percent, the number of persons over 65 covered by Blue Shield increased 21%. Thus, the growth rate of coverage for those over 65 is nearly four times that of all other age groups combined.

In 1959, only 10 Blue Shield plans offered individual non-group membership without age limit. Today, 73 out of the 74 United States Blue Shield plans, representing over 99% of the total membership in this country, have individual non-group coverage for persons over 65 available.

Apart from Blue Shield's progress in providing health insurance coverage on an individual basis to those over 65, a more significant development has been the increasing practice of both local and national labor and management groups to negotiate a provision in their health and welfare programs for the continued coverage of retired employees under the same arrangements and conditions as apply to their active employees.

A good example is the pattern adopted by the federal government for its retiring employees. Blue Shield, with Blue Cross, covers over 3,500,000 federal employees and their dependents. Each year, more than 25,000 retiring federal employees take their Blue Shield protection into retirement. These retired federal employees, like many retiring from private industry, are assisted by their former employer in continuing their health coverage.

Proponents of Medicare claim that figures on the number of persons over 65 covered by voluntary health insurance are misleading because in most cases, only the barest minimal coverage is provided. Blue Shield spikes that theory by pointing out that 65 of 73 Blue Shield plans pay for the entire cost of the medical-surgical protection of those over 65. The "paid-in-full" benefits apply to Blue Shield senior citizens even more completely than to members under 65.

Blue Shield realizes that those over 65 represent special health problems, as do the chronically ill, the handicapped and the indigent. In these cases, Blue Shield brings the resources of the entire community to bear upon these special problems.

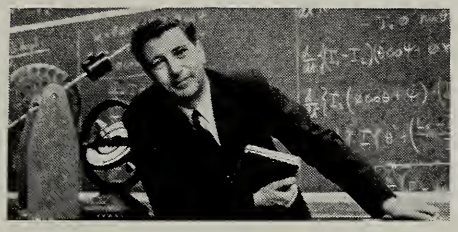
In its 25 year history, Blue Shield membership has grown to over 53 million persons. The number of those covered by voluntary health insurance in the United States has reached 145 million, 77% of the entire population.

Blue Shield feels that the proportion of the over 65 population covered by voluntary health insurance will soon match that of the entire population, with the quantity and quality of coverage for all people regardless of age continuing to improve at a rapid pace. ◄

W. C. Huddlestone
Public Relations Division

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Stoll[1] used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration, they were able to continue with and, in some cases, return to their daily work."

Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

*Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press *243*:578 (June 29) 1960.

SK&F **Smith Kline & French Laboratories, Philadelphia**

# ABSTRACTS

# BOOK REVIEWS

## ANIMAL BEHAVIOR AND DRUG ACTION

Ciba Foundation Symposium, edited by Hannah Steinberg, A. V. S. de Reuck and Julie Knight; Little, Brown and Co., Boston, Mass., 1964; 491 pages with numerous figures and tables; $13.00.

Psychopharmacology is an almost new offshoot of medicine. I really expected some difficult reading with many barriers to comprehension. It was my delight to find the authors talking on the medical student level. The language is crisp, clear and commendably concise. The tables help to underscore points that might be somewhat obscure otherwise.

A *very* large and chaotic subject becomes organized and comprehensible! The busy practitioner can leave this by his bedside and read here and there as time permits.

This is one Ciba symposium that can be unreservedly recommended for all levels of practioners of the medical arts!

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

# Abstracts From Various Literature, Prepared by AMA

## STUDIES SHOW A PATIENT MAY BE HIS OWN BEST DONOR

G. Miles, H. Langston, and W. Dalessandro (Augustana Hosp., Chicago)

*Mod. Hosp.* 102:104 (May), 1964.

In 1961, the possibility of obtaining blood from individuals who might require it at a later date was considered. Autologous blood offered certain advantages because it removed the inherent dangers of homologous blood in the form of infectious hepatitis or other transmittable diseases, as well as those of immunization to unidentified antigens and the dangers of mismatching. However, the limitations of autologous blood included the question of venesecting an individual who was scheduled to undergo surgery. It was realized that the patient who could not tolerate venesection of one or even two units of blood was a poor surgical risk. Furthermore, it was known that the one stimulus to blood production and the mobilization of the blood reserves was hemorrhage. Finally, it was felt that the stress of venesection would indeed better prepare the individual for surgery. Based on these principles, the authors expanded the use of autologous blood, and today, more than 200 patients have been venesected of one or more units (500 ml) of blood prior to major surgery. More than half of all the blood they received during surgery and the subsequent 48 hours was their own. Based upon these experiences, the authors' position today is as follows: An individual who is faced with elective surgery, and who might remotely require blood in the course of that operation, is venesected of one unit of blood.

## CIRCULATORY ASSISTANCE BY EXTERNAL PULSED PRESSURES

J. J. Osborn et al. (Presbyterian Medical Center, San Francisco)

*Amer. J. Med. Electronics* 3:87 (April-June), 1964.

The means of circulatory support without entering the blood stream and yet using external energy to help move blood were investigated. The first method was an adaptation of diastolic counterpulsation in which the arterial tree of the legs was used as an auxiliary ventricle. If the legs are suddenly compressed during systole, it is possible to synchonize systolic emptying of the left ventricle with the sudden arterial pressure drop caused by release of pressure on the legs and their contained arterial system. In ten mongrel dogs, dye dilution determination of a cardiac output showed a 33% rise in output during counterpulsation. Diastolic pressure was raised approximately 20 mm/Hg above systolic pressure. No apparent ill effects were noted in the animals studied. Assisted circulation by tracheal airway pulsation, the second method (positive in systole and negative in diastole) was demonstrated in mongrel dogs. These experiments then appeared to demonstrate that a systolic airway pulse did add to systolic ejection to outside the chest, but that the effect under the conditions of the experiments was not large. Even a rather mild, longer diastolic negative pulse lowered ventricular diastolic pressure and moved a large amount of venous blood into the chest with a net rise in cardiac output. No damage to the lungs was noted, but long-term experiments to determine the limits of danger were not carried out.

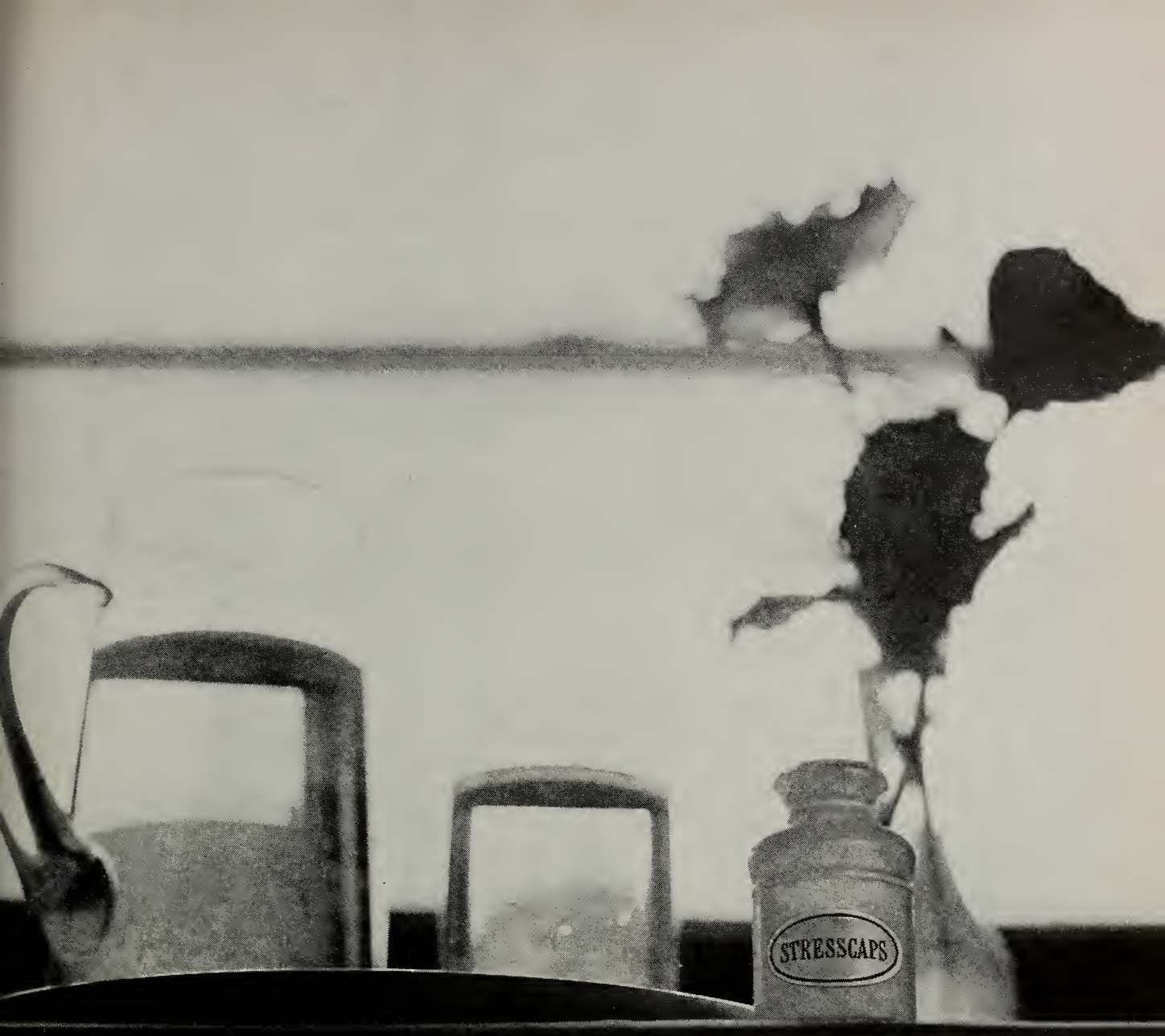
## CARDIOVASCULAR DECONDITIONING DURING CHAIR REST

L. E. Lamb (USAF School of Aerospace Medicine, Brooks AFB, Tex.), R. L. Johnson, and P. M. Stevens.

*Aerospace Med.* 35:646 (July), 1964.

One of the difficulties in studying the effects of weightlessness is separating its effects from the simple problem of physical inactivity. Six healthy subjects were studied in a simple, uncomplicated experiment using strict chair rest with immobilization as a means of achieving physical inactivity. The normal bed rest period for sleep was permitted for each 24-hour period. All six subjects had normal orthostatic tolerance by routine tilt-table studies prior to the inactivity. Five of the six subjects showed manifestations of orthostatic intolerance after approximately four days of the ex-

Continued




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periment. These manifestations ranged from dizziness to fainting and circulatory collapse. Nausea and vomiting were also seen. This study demonstrates that simple inactivity of sufficient degree over a short period of time, uncomplicated by the problems of weightlessness or simulated weightlessness, will cause adverse changes in circulatory dynamics to syncopal reactions or circulatory collapse.

## VULNERABLE CHILD SYNDROME

M. Green (1100 W. Michigan St., Indianapolis) and A. J. Solnit.

*Pediatrics* 34:58 (July), 1964.

This paper describes a study based on the hypothesis that children who are expected by their parents to die prematurely often react with a disturbance in psychosocial development and in the parent-child relationship. A group of clinical features constituting a "vulnerable child syndrome" is reported and described in 25 children with a history of an illness or accident from which they recovered, although the parents were expecting a fatal outcome. Outstanding clinical features include difficulty with separation, infantile behavior, bodily overconcern and school underachievement.

## ATYPICAL MANIFESTATIONS OF HYPERTHYROIDISM

E. A. Boxall (1401 W. Broadway, Vancouver, B.C.), R. W. Lauener, and H. W. McIntosh.

*Canad. Med. Assoc. J.* 91:204 (Aug. 1), 1964

Patients with hyperthyroidism usually present symptoms of hypermetabolism, with or without goiter or eye signs. Occasionally however, the chief complaints are not immediately suggestive of hyperthyroidism. Patients with hyperthyroidism are described who presented such atypical manifestations as periodic muscular paralysis, myasthenia, myopathy, encephalopathy, psychosis, angina pectoris, atrial fibrillation, heart failure without underlying heart disease, skeletal demineralization, pretibial myxedema, unilateral eye signs, and pitting edema of the ankles.

## NONMALIGNANT VARIATIONS IN MAMMOGRAPHY

P. Strax (Radiology, City Hospital Center, Elmhurst, N.Y.) and M. M. Pomeranz.

*Amer. J. Roentgen.* 92:21 (July), 1964.

Mammography has been promoted primarily as a procedure for detecting cancer and to differentiate it from the many nonmalignant variations of the breast. The authors submit a classification of these nonmalignant variations based on structures visualized. These variations can easily be distinguished from one another. The pathologist's nomenclature is replaced with the roentgenologic terms

Continued on page 170.

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All precautions applicable to intramuscular injection should be carefully observed. Intramuscular solutions should be injected well within the body of a relatively large muscle, such as the upper outer quadrant of the buttock or the lateral thigh; do not inject into the lower or middle thirds of the upper arm. Care should always be taken to avoid injecting into a blood vessel or major nerve. Subcutaneous or fat-layer injection should be avoided.
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based on the shadows actually seen on a mammogram. Such a study will lead not only to a better appreciation of the roentgenographic appearances of cancer but may also give the radiologist a greater insight into the changes that precede the malignant state.

## POTENTIAL HEALTH HAZARDS IN THE MULTIPLE-DOSE VIAL

A. L. Rosenzweig (V. A. Hosp., Richmond, Va.) *Hospitals* 38:71 (June 16), 1964.

Experimental evidence indicates that the rubber stopper on many multiple-dose vials is not self-sealing and presents a potential health hazard. Most vials are uncapped and unrefrigerated, and rarely is one dated to show when it was first used. Some vials leak when inverted, some show bits of rubber and foreign matter in the contents, and some have positive or negative pressures. The solution is often extravasated on the stopper, and the vial is often sticky and dirty. Sometimes the metal collar has been detached so that the stopper can be removed for pouring the sterile solution. Visual inspection of over 1,000 vials in one hospital established that no procedures exist for use of multiple-dose vials. Of this group, 214 vials were selected at random for culture and leakage studies. Rubber stoppers were covered with saturated aqueous methylene blue and allowed to remain in contact for 30 minutes to two hours. Of 214 rubber stoppers, 21 showed methylene blue on the underside, clear evidence of leakage through the needle track resulting from one or more punctures. Of the vials examined, 66 were empty 30 ml meperidine vials. All cultures were negative, but 11 out of 66 vials had stoppers that leaked. These vials had been pierced at least 30 times. Finally, it is recommended that greater use should be made of single-use disposable units, and rigid mandatory procedures must be established where multiple-dose vials are used to assure sterility of the contents and maintenance of asepsis.

## OVARIAN FUNCTION DURING AND AFTER LONG-TERM TREATMENT WITH OVULATION INHIBITORS

R. P. Shearman (Department of Obstetrics, University of Sydney, Sydney, NSW, Australia) *Lancet* 2:557 (Sept. 12), 1964.

The urinary excretion of ovarian steroids was studied in 117 patients taking six different compounds by mouth for contraception. Twenty full cycles were assayed in nine of these, and mid-cycle observations were made in the others. There was no evidence of ovaluation in any of the patients studied. In all but one, ovarian inhibition was complete. After treatment extending to five years, a normal ovulatory pattern was established in the first untreated cycle.

## CARCINOMA OF THE CERVIX IN PREGNANCY

T. J. Williams and C. B. Brack (550 N. Broadway, Baltimore) *Cancer* 17:1486 (Nov.), 1964.

At the Johns Hopkins Hospital a study of both pregnant and nonpregnant women with carcinoma of the cervix showed that treatment, if carried out promptly, is effective when the lesions are in the early stages. An early diagnosis is essential, and it must include (1) attention to a history of vaginal bleeding and discharge, (2) vaginal examinations with and without a speculum, (3) a routine cytological study, and (4) a histological evaluation when indicated. The acceptable therapy must be effected immediately. At this hospital, the treatment of carcinoma of the cervix in pregnant women was superior to that for nonpregnant women, probably because of the above factors. Improvement owing to early diagnosis was anticipated, since routine examinations and cytological study were performed early on the pregnant patients.

## OPERATIVE IMPLANTATION OF VILLOUS ADENOMAS INTO THE SOFT TISSUE

J. L. Silverman (Barnes Hosp., St. Louis) *Cancer* 17:1456 (Nov.), 1964.

A benign villous adenoma of the colon can be

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implanted into the surrounding soft tissue at the time of surgical excision, grow slowly, and appear clinically as a soft tissue tumor many years after the primary operation. Two cases are described of recurrences which occurred seven years and three years after the resection of the primary tumor. The histopathology of these cystic recurrences resembled that of the original villous tumors. Surgical treatment was successful in both instances.

## TREATMENT OF "REFRACTORY OBESITY" WITH A DIET OF TWO MEALS PER DAY

D. A. Seaton and L. J. P. Duncan (Royal Infirmary, Edinburgh, Scotland)
*Lancet* 2:612 (Sept. 19), 1964.

The results are reported of a trial of 1,000 calorie diet given for 12 weeks in the winter as two 500-calorie meals each day to 34 patients having "refractory obesity." The mean loss of weight was 8.9 lbs. Whereas over the same months in previous years these patients had gained an average of 3.4 lbs. This mean loss was greater than that achieved by several anorectic agents given to similar patients and was much the same as that observed with a formula diet; if allowance is made for the difference in time of year when the trials were conducted. The patients who adhered strictly to the regimen showed a mean weight loss of 11 lbs. and experienced no real difficulty. This regimen appeared to be an acceptable form of dieting for obese patients, and its suitability is discussed. ◄

# *About Our Cover*

Gabriel Lippmann (1845-1921), a French physicist born in Luxembourg, was one of the great pioneers of electrocardiography.

He became professor of Mathematical Physics at the Faculty of Science in Paris in 1883 and later became Professor of Experimental Physics and Director of Research Laboratories at the Sorbonne. Besides the important research he contributed in optics, thermodynamics and the measurement of time, he described a method for color photography for which he received world-wide recognition and the Nobel Prize in Physics in 1908.

In 1872, Lippmann invented the capillary electrometer, shown on this month's cover, which was based on the principle of polarization and tension of a surface of mercury covered with sulfuric acid. It was this instrument which first directly recorded the variations in potential from a human heart.

Although the curves were badly damped, they indicated to Willem Einthoven that the electrocardiogram might be useful in differentiating people with and without heart disease. This provided an impetus to Einthoven to attempt to find a more satisfactory galvanometer.

Despite the poor quality of the curves recorded with the capillary electrometer, many discoveries concerning the electrical activity of the heart were made with it and a great many of the fundamental principles of electrophysiology were learned through its use.

The first electrocardiogram recorded from man, shown in the lower part of this month's cover, was obtained with this instrument by Augustus D. Waller in 1887. The curve labeled "t" is the time curve in 0.05-second intervals; "h" is the cardioscope tracing and "e" is the electrometer recording. (Waller, A. D.: *J. Physiol.* 8:229, 1887, and *An Introduction to Human Physiology* [3d., London: Longmans, Green & Co., 1896].)

Our sincere thanks to George E. Burch, M.D., co-author of *A History of Electrocardiography,* for granting permission for us to use the illustration and to Year Book Medical Publishers, Inc., Chicago, publishers of the book, who loaned it to us.—J.F.S.

# WANTED: Locations Physicians

### GENERAL PRACTICE

R. Wood, 325 N. Monroe St., Monroe, Mich.

Dale F. Leonard, 496 South Hawkins Ave., Apt. 3, Akron, Ohio

### SPECIALISTS

Kenneth Eichosz, 1898 Twentieth St., N. W., Rochester, Minn.—*Anesthesiology*

Victor I. Spear, Martin Army Hospital, Ft. Benning, Ga.—*Dermatology*

Burwell Jones, 2408 Rolling Pines Ave., Durham, N. C.—*Dermatology*

George F. Ramsey, 3357 Wedgewood Dr., Augusta, Ga.—*Internal Medicine-Hematology*

Francis W. Logan, 2601 Radhor Rd., Delaware, Ohio 43015—*Industrial or Institutional*

Ronald M. Holloway, USAF Hospital, Chanute AFB, Ill. 61867—*Industrial or Insitutional*

Robert H. Kalinowski, Peace Corps, % American Embassy, Manila, Philippines—*Industrial or Institutional*

George Frailey, 2979 Northview Bldg., Youngstown, Ohio—*Industrial or Institutional*

Alfred J. Kobak, Jr., 5500 North Lakewood, Chicago, Ill.—*Ob-gyn*

Aubrey H. Haynes, 3822 Emerald Dr., Mesquite, Texas 75149—*Ob-gyn*

Bradley D. Adams, 98th General Hospital, APO, New York, N. Y.—*Ob-gyn*

B. W. Kreel, 318B Bataan Rd., Fort Lee, Va.—*Ob-gyn*

Vincente Rabasa, 719 W. Ocean View Ave., Norfolk, Va. 23503—*Pathology*

Milton W. Roggenkamp, 7207 18th Ave., N. W., Bradenton, Fla.—*Pathology*

Michael Yazitzis, Dept. of Pediatrics, Good Samaritan Hospital, Cincinnati, Ohio—*Pediatrics*

Robert H. Roy, 1522 Monticello Dr., Gladwyne, Pa. 19035—*Radiology*

Paul J. Driscoll, 103 New Jersey Ave., Fort Dix, New Jersey—*General Surgery*

Ray C. Smith, Jr., 39 Dunning Ave., Battle Creek, Mich.—*General Surgery*

A. R. Florcruz, 21027 Ellacott Parkway, Apt. 3-C, Warrensville Heights, Cleveland, Ohio—*General Surgery with General Practice*

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Fulton County—FULTON—Population 500 with a large surrounding area. Located in a rich farming area 14 miles from Logansport and 9 miles from Rochester where hospital facilities are available. Community will build an office for a physician. Community without the services of a physician since the death of Dr. Franklin Dielman who had practiced in the community for 60 years. Contact Mr. Richard Davidson, Box 68, Fulton, for details. ◄

## DO YOU HAVE A HEMOPHILIAC PATIENT?

**The Indiana State Chapter of the National Hemophilia Foundation is seeking information as to the number of hemophiliacs in Indiana. Medical practitioners throughout the state treating hemophiliac patients are urged to send the names, ages, addresses and details of the type of hemophilia of such patients to Mr. S. T. Friedman, Secretary of the Medical Advisory Council of the Indiana State Chapter of the National Hemophilia Foundation, 3946 Washington Blvd., Indianapolis 5.**

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### *Huntington Laboratories Continues Annual Scholarship Grants*

Huntington Laboratories is continuing its annual grant to the Hospital Research and Educational Trust of the American Hospital Association of $3,500 to provide ten scholarships for the Annual Course in Hospital Housekeeping at Michigan State University.

The course will be held this year from April 5 to May 27. Registration blanks and scholarship applications have been sent to hospitals. The deadline for applying is March 5.

### Dr. McGrath Donates FPA Plaques

Dr. M. F. McGrath, Indianapolis general practitioner and state chairman of the Flying Physicians Association, has placed plaques in 26 airports in the state which explain the purpose and aims of the Flying Physicians Association.

Because of his great interest and belief in the organization, Dr. McGrath personally underwrote the entire cost of making and installing the plaques.

The Flying Physicians Association was founded in 1954 to promote general aviation safety and to assist in the nation's Civil Defense efforts. Dr. Frank Coble, Richmond, was one of the originators of the national organization. There are currently 116 members in Indiana and over 1,600 in the nation.

### *New Executive Secretary Named*

Mrs. Polly Tomlinson Dent has been selected as the new executive secretary of the LaPorte County Medical Society to replace Ernest P. Messner, who has retired.

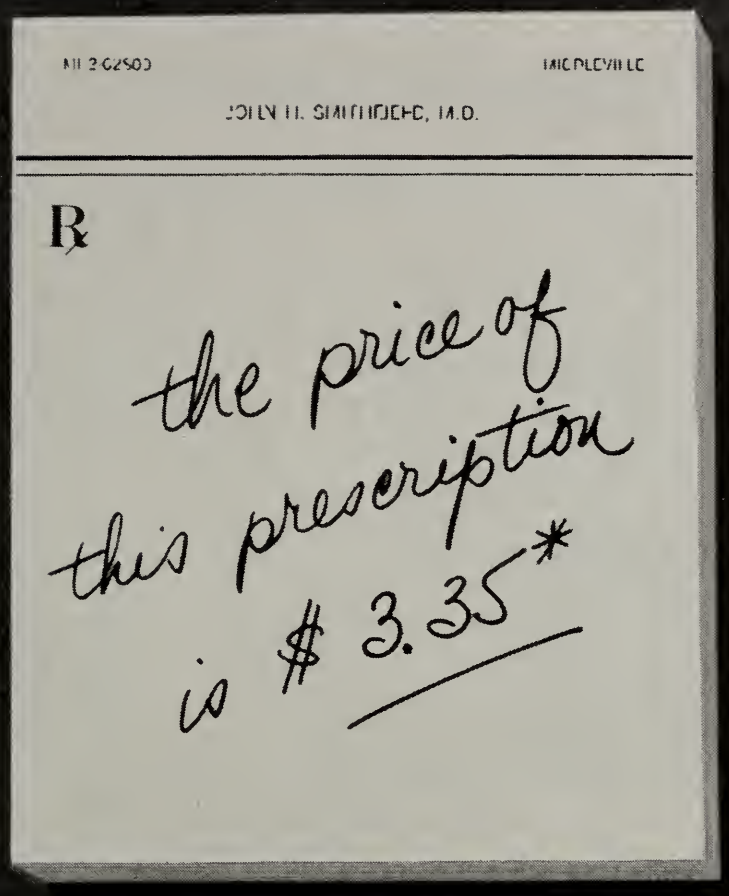
All future correspondence should be directed to the society's new address at 903 Indiana Ave., LaPorte 46350.

### Student Wins Scholarship From Betsey Barton Fund

Max Wayne Hammonds, son of Mr. and Mrs. Leslie Hammonds, 708 North Sycamore St., North Manchester, a student in the first year at the Indiana University School of Medicine in Indianapolis, has been awarded the first scholarship deriving from the Betsey Barton Fund for Neurological Research. He did his pre-medical work at Manchester College.

The fund was created this year in honor of the late Betsey Barton, daughter of Bruce Barton, New York, author and advertising executive, by her family and friends. It is expected that it will grow to fellowship or even larger proportions. Miss Barton had a profound interest in neurological research and the purpose of the memorial is to support work in that field under the direction of Dr. Leslie W. Freeman, professor of surgery and director of the surgical experimental laboratories, at the I. U. Medical School.

The contributions to the Betsey Barton Fund are among gifts for the benefit of the I.U. School of Medicine in the program now under way among alumni and friends of the school. Such gifts are to establish other scholarships, to increase student loan funds and to support other programs at the medical school which would not be possible without such assistance. More than 400 alumni of the school throughout the country are working on local committees. ◄




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# *Annual Meeting Dates of Professional Medical and Allied Organizations*

**AMERICAN MEDICAL ASSOCIATION CONVENTION**
Date June 20-24, 1965
Place New York, N. Y.

**AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER**
Date May 2-5, 1965
Place Aboard the Delta Queen Riverboat, leaving from Cincinnati, O.

**BONE AND JOINT CLUB**
Date April 14, 1965
Place The Athenaeum, Indianapolis

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date March 9-11, 1965
Place Murat Temple, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 19, 1965
Place Indianapolis

**INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS**
Date May 15, 1965
Place Indianapolis Athletic Club

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 13-15, 1965
Place Murat Temple, Indianapolis

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

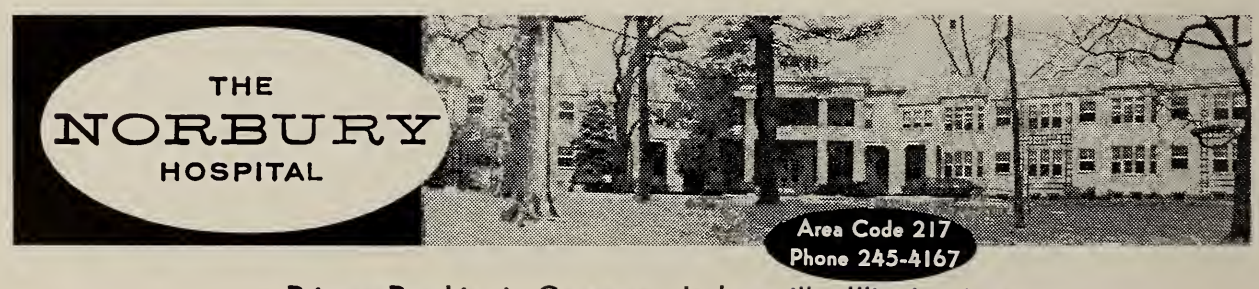
**INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**
Date May 7-8, 1965
Place Oakbrook, Ill.

**INDIANA ORTHOPAEDIC SOCIETY**
Date June 25-26, 1965
Place Marott Hotel, Indianapolis

**INDIANA CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS**
Date April 21-22, 1965
Place Marott Hotel, Indianapolis

**INDIANA ROENTGEN SOCIETY**
Date May, 1965
Place Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


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Over the years, the professional consensus has reflected broad clinical confidence in the marked benefits to be achieved by DONNATAL in a wide range of visceral disorders... in peptic ulcer,[1,6] functional bowel distress,[1] gastrointestinal spasm and discomfort,[2] and other functional disturbances of visceral smooth muscle.

CONTRAINDICATIONS: Glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.

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SIDE EFFECTS: Blurring of vision, dry mouth, difficult urination or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dose.

*This one at Oak Creek, Castle Rock, Arizona

References: 1. Hock, C. W.: Clin. Med. 8:1932, 1961. 2. Marks, L.: Am. J. Gastroenterol. 27:180, 1957. 3. Palmer, W. L., and Kirsner, J. B.: Therapeutics in Internal Medicine, 2nd ed., F. A. Kyser, Ed., Hoeber, New York, 1953, p. 368. 4. Ryan, J. P., Jenkins, H. J. and Robinson, S. M.: J. Pharmaceut. Sciences 53(9):1084, 1964. 5. Vollmer, H.: Arch. Neurol. & Psychiat. 43:1057, 1940. Abst. J.A.M.A. 115:333, 1940. 6. Wharton, G. K., Balfour, D. C., Jr., and Osman, K. I.: Postgrad Med. 21:406, 1957.

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| 0.1037 mg. | hyoscyamine sulfate | 0.3111 mg. |
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| 0.0065 mg. | hyoscine hydrobromide | 0.0195 mg. |
| 16.2 mg. (¼ gr.) | phenobarbital (¾ gr.) | 48.6 mg. |

(Warning: May be habit forming.)

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—December, 1964

| Disease | Dec. 1964 | Nov. 1964 | Oct. 1964 | Dec. 1963 | Dec. 1962 |
|---|---|---|---|---|---|
| Animal Bites | 403 | 603 | 896 | 339 | 397 |
| Chickenpox | 766 | 404 | 205 | 452 | 754 |
| Conjunctivitis | 123 | 77 | 124 | 49 | 103 |
| Diphtheria | 0 | 0 | 0 | 0 | 1 |
| Dysentery, Unspecified | 99 | 28 | 237 | 65 | 65 |
| Gonorrhea | 349 | 299 | 262 | 293 | Not Available |
| Impetigo | 133 | 95 | 198 | 54 | 88 |
| Infectious Hepatitis | 38 | 28 | 43 | 48 | 71 |
| Infectious Mononucleosis | 63 | 52 | 47 | 32 | 21 |
| Influenza | 820 | 665 | 911 | 429 | 1329 |
| Measles (Rubeola-Rubella) | 188 | 130 | 158 | 464 | 234 |
| Meningitis, Meningococcal | 5 | 5 | 4 | 6 | 2 |
| Meningitis, Other | 8 | 9 | 8 | 5 | 12 |
| Mumps | 652 | 287 | 173 | 302 | 153 |
| Pertussis | 33 | 22 | 50 | 6 | 68 |
| Pneumonia | 261 | 238 | 242 | 210 | 167 |
| Poliomyelitis | 0 | 1 | 2 | 0 | 3 |
| Streptococcal Infection | 611 | 426 | 497 | 337 | 436 |
| Syphilis | | | | | |
| Primary & Secondary | 5 | 9 | 9 | 5 | Not Available |
| All Other Syphilis | 84 | 101 | 118 | 94 | Not Available |
| Tinea Capitis | 45 | 11 | 47 | 1 | 33 |
| Tuberculosis (Active) | 81 | 87 | 120 | 102 | 96 |


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| 'Sudafed'® brand Pseudoephedrine Hydrochloride | 20 mg. |
| 'Perazil'® brand Chlorcyclizine Hydrochloride | 15 mg. |
| Phenacetin | 150 mg. |
| Aspirin | 200 mg. |
| Caffeine | 30 mg. |

**To relieve the aches, pains, fever and respiratory congestion of the common cold, flu or grippe with one product ...specify 'Emprazil'.**

Caution: While pseudoephedrine is virtually without pressor effect in normotensive patients, it should be used with caution in hypertension. Also, while chlorcyclizine has a low incidence of antihistaminic drowsiness, the usual precautions should be observed.

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# FUTURE MEETINGS, SEMINARS, COURSES

## *American Academy of Pediatrics Schedules Spring Session April 26-29*

The American Academy of Pediatrics invites all pediatricians and other physicians interested in problems of childhood to attend its spring session, April 26 to 29, at the Americana Hotel, Bal Harbour, Florida.

The scientific portion of the program will be conducted on the mornings of the four days, leaving the afternoons for recreation. One feature of the meeting will be simultaneous translation into Spanish of all presentations.

Registration fee for non-members is $25. Program and reservation forms may be obtained by addressing the Academy at 1801 Hinman Ave., Evanston, Illinois 60204.

## Ninth Postgraduate Course in Trauma Offered in Chicago

The ninth postgraduate course in trauma will be given by the Chicago Committee on Trauma April 28 to May 1, inclusive, at the John B. Murphy Memorial Auditorium, Chicago.

A full faculty of authorities, including Dr. Jorg Bohler of the University of Vienna, will present the course. Registration fee is $75. For program and other details write Dr. John J. Fahey, 1791 W. Howard St., Chicago 60626.

## *ISMA Members Invited to Genito-urinary Disease Symposium*

The Department of Radiology of the University of Kentucky will conduct a week-long "Symposium on Genito-urinary Disease" at Lexington from March 29 to April 2. The program is designed to appeal to all physicians and surgeons who are interested in the genito-urinary system.

Guest speakers from all over the U.S. will participate. Members of ISMA are invited to attend. The fee is $75.00 for the entire course and $20.00 for one day. Information may be obtained by writing Dr. Nicholas Pisacano, University of Kentucky College of Medicine, Lexington 40506.

## *First Annual Child Care Conference Set for April 21-22 at Indianapolis*

The first annual Child Care Conference sponsored by the Indiana chapter of the American Academy of Pediatrics, the Department of Pediatrics of the Indiana University Medical Center and the Indiana State Board of Health will be held April 21 and 22, 1965 at the Marott Hotel. The meeting will consist of 16 seminars with each session directed by a national authority in the particular field concerned. The seminar titles and leaders are:

Reading Problems—Dr. Newell C. Kephart, Purdue University; The Environmentally Deprived Infant—Dr. Sally Provence, Yale University; School Underachievement: Emotional and Socio-Cultural Factors—Dr. Milton J. E. Senn, Yale University; The Child In the Hospital—Mrs. Emma N. Plank, Western Reserve University; The Infant with Birth Defects and His Family—Dr. Albert J. Solnit, Yale University; Prenatal Pediatrics—Dr. Sterling Garrard, State of New York College of Medicine; Communication Disorders—Dr. Helmer R. Myklebust, Northwestern University; The Deaf Child—Dr. Myklebust; Reading Problems—Dr. Ralph D. Rabinovitch, Hawthorn Center, Northville, Michigan; Physical Rehabilitation Programs for Children—Dr. Nadene Coyne, Western Reserve University.

Further information may be obtained from Dr. Morris Green, 1100 West Michigan Street, Indianapolis, Indiana 46207. The meeting is open to all physicians in Indiana. Registration fee will be $10.

## Ob-Gyn Board Lists Closing Date for Applications

Applications and letters of request from previous applicants requesting to be scheduled for the forthcoming Part I examination of this board to be given July 2, 1965 will be accepted in the board office up until the closing date of February 28, 1965. Applications and letters of request postmarked after that date will be returned to the sender.

Application forms and bulletins may be obtained by writing to the office of the Secretary, Clyde L. Randall, M.D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

Servicemen applying for the Part I examination are requested to submit the name of their Commanding Officer.

## American Society for the Study Of Sterility Will Meet in April

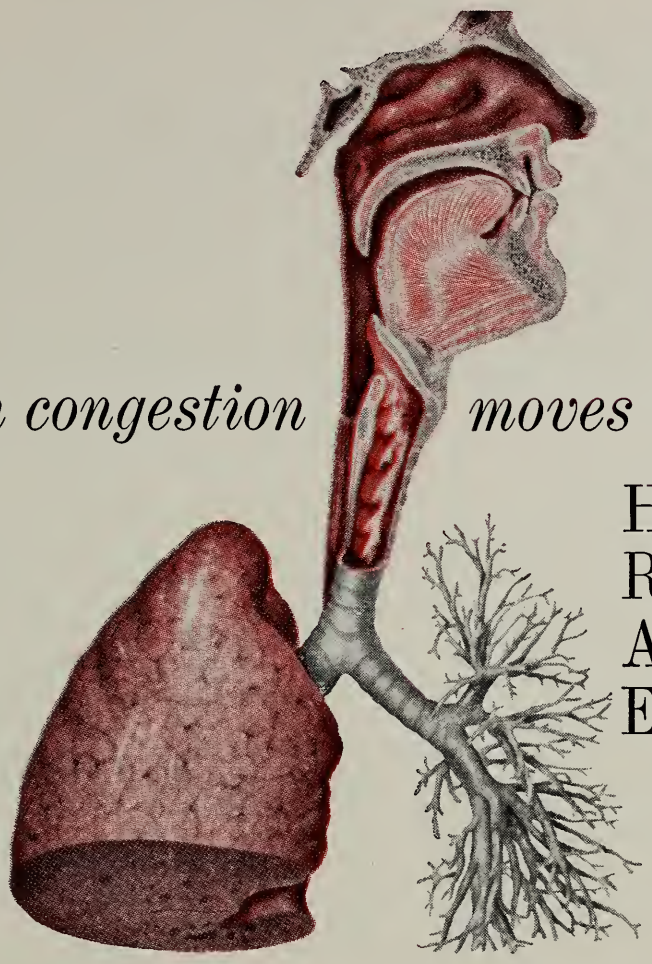
All physicians are invited to attend the annual meeting of the American Society for the Study of Sterility to be held at San Francisco on April 2 to 4.

Non-member registration fee is $10.00. Program and details may be obtained from Dr. William H. Robertson, 2700 Tenth Ave., S., Birmingham, Alabama 35205.

## Aerospace Medical Association 36th Annual Meeting in April

The Aerospace Medical Association will hold its 36th Annual Scientific Meeting in the New York Hilton Hotel, April 26 to 29. More than 200 carefully selected scientific papers will be presented. All phases of air and space medicine will be

Continued



*when congestion moves down*

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# HYCOMINE® SYRUP

Each teaspoonful (5 cc.) contains:

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| Hycodan® | |
| Hydrocodone bitartrate . . 5 mg. | |
| (Warning: May be habit-forming) | 6.5 mg. |
| Homatropine methylbromide . . . . . 1.5 mg. | |
| Pyrilamine maleate . . . . . | 12.5 mg. |
| Phenylephrine hydrochloride . . . . . | 10 mg. |
| Ammonium chloride . . . . . | 60 mg. |
| Sodium citrate . . . . . | 85 mg. |

(with methylparaben 0.13% and propylparaben 0.02% as preservatives)

*in a highly palatable cherry-flavored vehicle*

## treats the multiple symptoms of the COUGH/COLD syndrome

• arrests both productive and nonproductive cough • decongests the airways • liquefies secretions responsible for irritation • provides prompt symptomatic relief of allergic symptoms • is well tolerated • rarely causes constipation

**DOSAGE:** *Average adult dose*—1 teaspoonful after meals and at bedtime with food. *Children 6-12 years,* ½ teaspoonful; *3-6 years,* ¼ teaspoonful; *1-3 years,* 10 drops; *6 months to 1 year,* 5 drops. Administer after meals and at bedtime with food. **On oral Rx where state laws permit.**

**CAUTION:** Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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covered. Full information may be obtained by writing Dr. William J. Kennard, Washington National Airport, Washington, D. C. 20001.

### *Cleveland Clinic Announces Continuation Course in Urology*

The Cleveland Clinic Educational Foundation will present a postgraduate continuation course in urology March 17 and 18 at Cleveland.

Registration fee is $30.00. Further information on the course may be obtained by writing the Educational Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

### *AMA Congress on Environmental Health to Meet April 26-27*

The Second Congress on Environmental Health will meet under the auspices of the AMA at the Drake Hotel in Chicago, April 26 and 27. The purpose of the congress is to broaden understanding of the interaction between man and his environment.

Influences varying from the ultravirus, and the effect of population concentration to the effects of outer space and undersea environments will be discussed. For further information write Dr. Raymond L. White, 535 N. Dearborn, Chicago 60610.

### Ob-Gyn College Lists Clinical Meeting for April

Members of ISMA are invited to attend the clinical meeting of the American College of Obstetricians and Gynecologists to be held in San Francisco April 4 to 8.

Registration is open to all physicians; the registration fee is $25.00. Preliminary program, housing and registration forms may be obtained by writing the college at 79 W. Monroe St., Chicago 60603.

### *Sixth Annual Congress of the Professions Will Be March 26-27*

The sixth Annual Congress of the Professions will be held in Grand Rapids, Michigan, March 26-27, 1965, at the Pantlind Hotel.

This congress, sponsored by the Michigan Association of the Professions, annually attracts seven to eight hundred professional people and officials of professional organizations from 20 to 25 states.

Invited to participate this year are officers and members of the Indiana State Medical Association.

Although delegates from the state and local societies of the MAP professions attend the two-day session, attendance is open to all members of each of the eight professions represented in MAP, i.e., architecture, dentistry, education, engineering, law, medicine, pharmacy and veterinary medicine. ◄

## SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 12-14, 1965, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

_____

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Name_____

Address_____

City_____

State_____

# County, District News

## Allen

Dr. Ovid O. Meyer, of the University of Wisconsin, spoke on "Common Errors in Medical Diagnosis" at the Jan. 5 meeting of the Allen County Medical Society. There were 80 members attending.

## Delaware-Blackford

Dr. Donald R. Taylor is the newly elected president of the Delaware-Blackford County Medical Society. Other officers are: Drs. Jack M. Walker, secretary; James A. McClintock, treasurer; Thomas M. Brown, Glynn A. Rivers and Dean B. Jackson, delegates and Clyde G. Botkin, Ross L. Egger and Richard Ingram, alternates.

## Dubois

The Dubois County Medical Society has elected the following as its new officers: Drs. Allen D. Scales, president; Jack D. Bland, vice-president; Hubert Erhart, secretary-treasurer; John H. Barrow, delegate and Edward Ploetner, alternate.

## Fayette-Franklin

New officers of the Fayette-Franklin County Medical Society are: Drs. F. H. Neukamp, president; Bertram W. Sanders, vice-president; J. L. Steinem, secretary-treasurer; W. F. Kerrigan and H. N. Smith, delegates and A. M. Hudson and Perry F. Seal, alternates.

## Fountain-Warren

Dr. J. E. Fisher is the newly elected president of the Fountain-Warren County Medical Society. Assisting him will be Drs. Lowell Stephens, vice-president and delegate; J. W. Crain, secretary-treasurer and delegate and Drs. Max Hoffman and Carl A. Nelson, alternates.

## Gibson

New officers of the Gibson County Medical Society are: Drs. James F. Peck, president; William R. Wells, vice-president; William E. Dye, secretary-treasurer; R. E. Weitzel, delegate and V. P. McCarty, alternate.

## Greene

Officers of the Greene County Medical Society for 1965 will be: Drs. Robert E. Moses, president; Kenneth Broshears, vice-president; Harry Rotman, secretary-treasurer and delegate and H. B. Turner, alternate.

## Jefferson-Switzerland

Dr. G. F. Harris is the new president of the Jefferson-Switzerland County Medical Society; Dr. Noel S. Graves the vice-president and Dr. Ott B. McAtee secretary-treasurer. Delegate will be Dr. Robert O. Zink and alternate Dr. Francis W. Hare, Jr.

## Knox

The Knox County Medical Society has elected the following new officers: Drs. John B. Anderson, president; Robert J. Nichols, vice-president; E. R. Cantwell, secretary and Jack L. Shanklin, treasurer. Dr. Herbert O. Chattin will be delegate and Dr. Walter R. Vaughn, alternate.

## LaGrange

New officers of the LaGrange County Medical Society are: Drs. M. Reed Taylor, president; Lloyd R. Studebaker, vice-president; Charles Benedict, secretary-treasurer; Philip E. Yunker, delegate and John H. Williams, alternate.

## Lake

Dr. C. O. Almquist is the new president of the Lake County Medical Society. Other new officers are: Drs. Vincent Santare, president-elect, and L. Dale Olson, secretary-treasurer.

## Miami

The Miami County Medical Society has elected the following as new officers: Drs. H. E. Randel, president; Parker W. Snyder, vice-president; Gordon C. Crates, secretary-treasurer and Lloyd L. Hill, delegate.

## Owen-Monroe

Dr. Joseph F. Milan is the new president; Dr. H. Richard Schell, vice-president and Dr. William


The alcoholic *CAN* be rehabilitated

With a unique background of 80 years' experience, The Keeley Institute has earned an international reputation as a specialized hospital for the *restorative treatment* of the "problem drinker."

Our progressive, well-rounded regimen includes:

- gradual withdrawal
- physical rehabilitation
- re-orientation
- re-education

Individual and group care are conducted in a friendly, cooperative atmosphere under the direction of physicians and experienced personnel. *We take female as well as male patients.*

Write for detailed, descriptive information on our low cost, comprehensive services—or phone 815 584-3001. We welcome your referrals.

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Dwight, Illinois
Member American Hospital Association
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Licensed by the Department of Public Health, State of Illinois

C. Link, secretary-treasurer, of the Owen-Monroe County Medical Society.

### Parke-Vermillion

Members of the I. U. Medical Center eye bank discussed their work at the Jan. 12 meeting of the Parke-Vermillion County Medical Society. Colored slides on the subject were shown.

### Putnam

Dr. James Sett discussed "Esophagoscopy and Bronchoscopy" at the Jan. 8 meeting of the Putnam County Medical Society. There were 15 members present.

### Sullivan

The Sullivan County Medical Society has elected the following new officers: Dr. J. S. Brown, president and secretary-treasurer; Dr. William H. Daugherty, vice-president; Joe E. Dukes, delegate and J. H. Crowder, alternate.

### Vigo

Dr. Don M. Mattox is the 1965 president of the Vigo County Medical Society. Other new officers include: Drs. J. L. Stoelting, vice-president; Hubert T. Goodman, secretary-treasurer; Drs. S. R. Combs and Thomas J. Conway, delegates and Fred W. Dierdorf and Norman M. Silverman, alternates.

### Warrick

Dr. Peter B. Hoover has been elected president of the Warrick County Medical Society. Dr. Robert H. Terry was elected secretary-treasurer and Dr. Wendell C. Stover, delegate.

### Wells

Dr. John F. Phillips is the new president of the Wells County Medical Society. Other new officers are: Drs. Charles E. Boonstra, vice-president; David G. Pietz, secretary-treasurer; Truman E. Caylor, delegate and Dr. Phillips, alternate.

### Whitley

Dr. Frederick G. Perry, dermatologist from Fort Wayne, spoke on "What's New in Dermatology" at the Jan. 12 meeting of the Whitley County Medical Society. ◄

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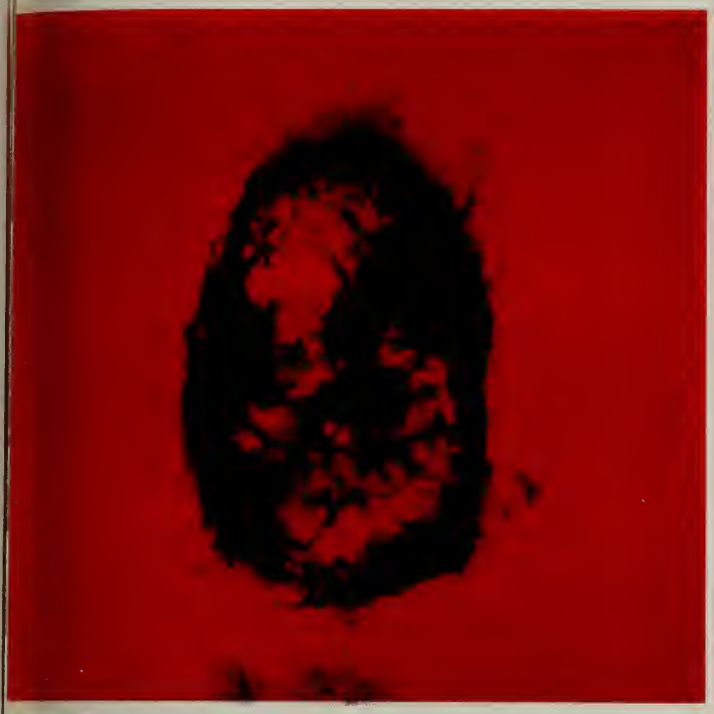
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# kills Haemophilus influenzae in respiratory infections



*Electron micrograph of normal* H. influenzae *organism.*



*Electron micrograph of* H. influenzae *after a 2-hour exposure to a therapeutic (8γ/ml.) dose of PENBRITIN (ampicillin).*

*New broad-spectrum penicillin:*

- most active antibiotic against *Haemophilus influenzae*[1-3]—a major pathogen in chronic bronchitis and respiratory infections in children
- demonstrated clinical efficacy and safety in chronic bronchitis[4-10]
- more effective than tetracycline in reducing sputum in chronic bronchitis[5]

*Usual Adult Dosage:* 250 mg. every six hours. *Usual Dosage for Children*—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

*Contraindications:* (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci or other penicillinase-producing organisms.

*Side Effects:* Mild effects, such as skin rashes, diarrhea, nausea and vomiting, have occasionally appeared.

*Precautions:* As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

*Supplied:* No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

*References:* 1. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:1159 (April 28) 1962. 2. Ivler, D., *et al.:* Abstracts, Third Interscience Conference on Antimicrobial Agents and Chemotherapy, October 1963, p. 32. 3. Stewart, G. T.: Pharmakotherapia *1*:197, 1963. (Progress in Drug Therapy). 4. Grant, I. W. B., *et al.:* Brit. M. J. *ii*:482 (Aug. 18) 1962. 5. Millard, F. J. C., and Batten, J. C.: Brit. M. J. *i*:644 (March 9) 1963. 6. Oswald, N. C.: Postgrad. Med. *35*:233 (March) 1964. 7. Howells, C. H. L., and Tyler, L. E.: Brit. J. Clin. Pract. *17*:321 (June) 1963. 8. May, J. R., and Delves, D. M.: Thorax *19*:298, 1964. 9. May, J. R., *et al.:* Lancet *ii*:444 (Aug. 29) 1964. 10. Pines, A.: Lancet *ii*:445 (Aug. 29) 1964.

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## Brand of Ampicillin

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# Deaths

## *Augustus P. Hauss, M.D.*

Dr. Augustus P. Hauss, president of the Indiana State Medical Association in 1949, died Dec. 30 at New Albany at the age of 76.



Dr. Hauss, member of the Floyd County Medical Society and the 50-Year Club, was president during the association's centennial year.

His years of service to the association began in 1941 with his appointment to the Committee on Physical Therapy. During later years he served on the following committees: Public Policy and Legislation; Health Insurance; Industrial Health; Study of Lay Activity in Medical Practice; Pre-payment of Medical and Surgical Service; Indiana Inter-Professional Health Council; Budget; Centennial Celebration and History; Medical and Nursing School Scholarships; Grievance; Physician-Patient Relations.

Besides serving on the Council and the Executive Committee, Dr. Hauss was co-chairman of the Committee on Convention Arrangements and chairman of both the Committee on Prepaid Medical and Hospital Insurance and the Board of Appeals on Patient-Physician Relations.

### Charles S. Boyd, M.D.

Dr. Charles S. Boyd, of East Chicago, died suddenly Nov. 29 at St. Catherine's Hospital. He was 65.

Dr. Boyd was graduated from the Howard University Medical School in 1927 and had been in general practice in East Chicago all of his medical career. He had been a member of the Lake County Medical Society for 27 years; was on the senior staff of St. Catherine's Hospital and served 15 years on the East Chicago Board of Health.

### Ralph T. Levin, M.D.

Dr. Ralph T. Levin, 60, former chief of radiology at the Cold Spring Road Veterans Administration Hospital and staff member of the radiology department at the I. U. School of Medicine, died Jan. 2 at his home.

Graduated from Yale University in 1926, Dr. Levin received his degree in medicine from the New York City School of Medicine in 1930. Later he served on the staffs of Sydenham, Montefiore and Harlem Hospitals. During World War II, he served in the Pacific area as a U.S. Navy commander.

Dr. Levin was a member of the Marion County Medical Society and was a diplomate of the American College of Radiologists.

# Association News

## EXECUTIVE COMMITTEE

November 22, 1964

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D.; Lester H. Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*, and J. A. Waggener, executive secretary.

### Membership Report:

| | |
|---|---|
| Number of members as of October 31, 1963 | 4,350 |
| 1964 members as of October 31, 1964: | |
| Full dues paying | 3,794 |
| Residents and interns | 133 |
| Council remitted | 47 |
| Senior | 326 |
| Honorary | 3 |
| Military | 52 |
| Total 1964 members as of October 31, 1964 | 4,355 |
| Number of members as of October 31, 1963 | 4,350 |
| Gain over last year | 5 |
| Number of AMA members as of October 31, 1964 | 4,248 |
| Total 1963 AMA members as of October 31, 1963 | 4,239 |
| Gain over last year | 9 |
| 1964 AMA members: Dues paying | 3,688 |
| Exempt, but active | 560 |
| | 4,248 |
| Number who have paid state dues but not AMA dues as of October 31, 1964 | 107 |

### Headquarters Office

Correspondence was read concerning the insurance proposal for employed M.D.'s whereby a percentage of their salary could be diverted tax free for a retirement program. Upon motion of Drs. Rifner and Black this matter is to be referred to the Commission on Medical Economics and Insurance for study.

### Building Matters

A report was made concerning the progress of negotiations with Mr. John Spoden concerning the exit from the parking lot to Fortieth Street, and this matter will be continued until such time as the draft of agreement is prepared by the attorney.

### Treasurer's Office

The treasurer reported on the balance in funds and expenditures for the month of October and his report was approved on motion of Drs. Neumann and Rifner.

Renewal of membership in the Indiana State Chamber of Commerce was approved on motion of Drs. Neumann and Olvey.

### Annual Convention, Indianapolis, October 13, 14 and 15, 1964

The president's recommendations, as approved by the House of Delegates, were reviewed and the secretary reported on the letters of appreciation from exhibitors and others concerning the 1964 convention.

The secretary reported on the instructional course attendance, and it was taken by consent that a recommendation be made that the Indiana Academy of General Practice and the sections be responsible for planning a program of instructional courses.

The results of the Gaslight party were reviewed and upon motion of Drs. Black and Neumann, it was recommended that the party be repeated in 1965 and that there be an increase in the admission price.

### Legislation

*National*: The secretary reported on proposed changes in the Hill-Burton law.

*Local*: The resolution on the new health officers bill made by the committee was approved on motion of Drs. Larson and Black.

### Organization Matters

The Guide on Hospital Disaster Planning was assigned to the Commission on Governmental Medical Services for study.

A letter, written by Dr. Offutt and addressed to Mr. TeKolste concerning the Hospital Facilities Planning Council was read.

A letter sent by the association to Mr. William E. Wilson, superintendent of the Indiana State Department of Public Instruction, was read for the information of the committee and its contents approved by consent.

The secretary reported on the gift of $1,000.00 from Dr. M. A. Austin, to assist the student loan plan and read a letter of appreciation which had been mailed to Dr. Austin. Upon motion of Drs. Neumann and Olvey, this $1,000.00 is to be placed in the Guaranteed Loan Fund.

A letter from the Indiana Neuropsychiatric Association was read for the information of the committee.

Correspondence was read concerning a matter which has been before the committee for some time and a recommendation of the Commission on Medical Education and Licensure was reviewed, and the secretary was requested to advise the commission of the policy of the association in matters such as this.

A letter was read from the Department of Health, Education and Welfare, which the committee accepted as information only.

Contents of a letter received from the attorney general of the State of Illinois were noted, but no action was taken.

A letter addressed to the American Medical Association by an Indiana physician was read for the information of the committee.

A letter recommending Dr. Rifner for a position on the Medical Advisory Board of the Sears-Roebuck Foundation was reviewed and approved.

A summary of the actions taken by the Board of Trustees of the American Medical Association at its September meeting was reviewed for the information of the committee.

Letter to Dr. Roland Miller was reviewed for

the information of the committee and the contents of the letter approved by consent.

Dr. Offutt appeared before the committee and discussed the present composition of the State Board of Health, and upon motion of Drs. Larson and Rifner, the committee agreed that the present make-up is adequate. In the same motion, the Commission on Legislation is to watch this legislation which might tend to change the composition of the Board.

## New Business

Plans for the Miami meeting of the AMA were reviewed and it was decided to meet with the delegates on Saturday night, November 28, at Miami.

## The Journal

A plan for conducting a readership survey by *The Journal* was approved in principle on motion of Drs. Neumann and Black.

## Future Meetings

Conference on Blood Banking, Chicago, December 11-12, 1964. By consent Dr. Lester Hoyt is to represent the association at this meeting.

Conference on Kerr-Mills, Chicago, January 16-17, 1965. The co-chairmen of the Commission on Legislation or staff should attend this meeting.

Upon motion of Drs. Black and Rifner, the association is to get out stories to the newspapers of the state concerning the implementation of Kerr-Mills in Indiana.

Conference on Aging, Chicago, February 4-6, 1965. It was noted that Dr. Nathan Salon had been requested to appear on this program and it was considered that this would be ample representation.

AMA 11th Annual Conference on Mental Health, March 5 and 6, 1965. No representative will be sent to this meeting.

Conference on Rural Health, Miami Beach, March 26 and 27, 1965. No representative will be sent to this meeting.

There being no further business, the committee adjourned, to meet again upon the call of the chairman. ◄

# COMMERCIAL ANNOUNCEMENTS

ASSOCIATE desired for two man general practice in small Indiana town 15 miles from South Bend. Inspection of our modern facility and personal discussion of this opportunity invited. Reply to Box No. 306, The Journal, ISMA, 3935 North Meridian St., Indianapolis, Ind.

OUTSTANDING opportunity for physician specializing in internal medicine to be affiliated with well established group in large metropolitan center. Five internists practicing in group. Compensation excellent and no investment necessary. Reply to Box 310, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

FOR RENT: Bungalow office to share with dentist in S.E. Fort Wayne residential area. Four rooms designed for physician; office area and reception room. Available March, 1964. Call 744-3411.

1964 I.U.M.S. graduate seeks association in general practice with two or more physicians in established group or clinic in northern part of Indiana. Age 25 years, married, two children; military service completed. Presently serving internship at Ancker Hospital, St. Paul, Minn. Write: Stephen H. Earl, M.D., Ancker Hospital, St. Paul, Minn.

GENERAL Practice office for sale; five rooms, air conditioned, records included, excellent location near three hospitals and close to excellent residential area; large parking lot. Leaving in July to specialize. Contact: Michael Truman, M.D., Hamilton, Ohio — 89-54541.

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

ISMA members may repeat an ad in the following issue without charge. This is limited to one free ad per year.

Advertiser will be billed at the end of the designated period of insertion(s), or at the end of each three-month period, whichever is shorter.

DEADLINE: Fifth day of month PRECEDING month of issue. (The Journal is in press approximately one month.)

## SPECIAL NOTICE

June issues and the 1964-65 Roster may be obtained from the JOURNAL, 3935 N. Meridian, Indianapolis.

Roster: $3.00 each.

Yearbook: $5.00 each.

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Volume 58 February 1965 No. 2

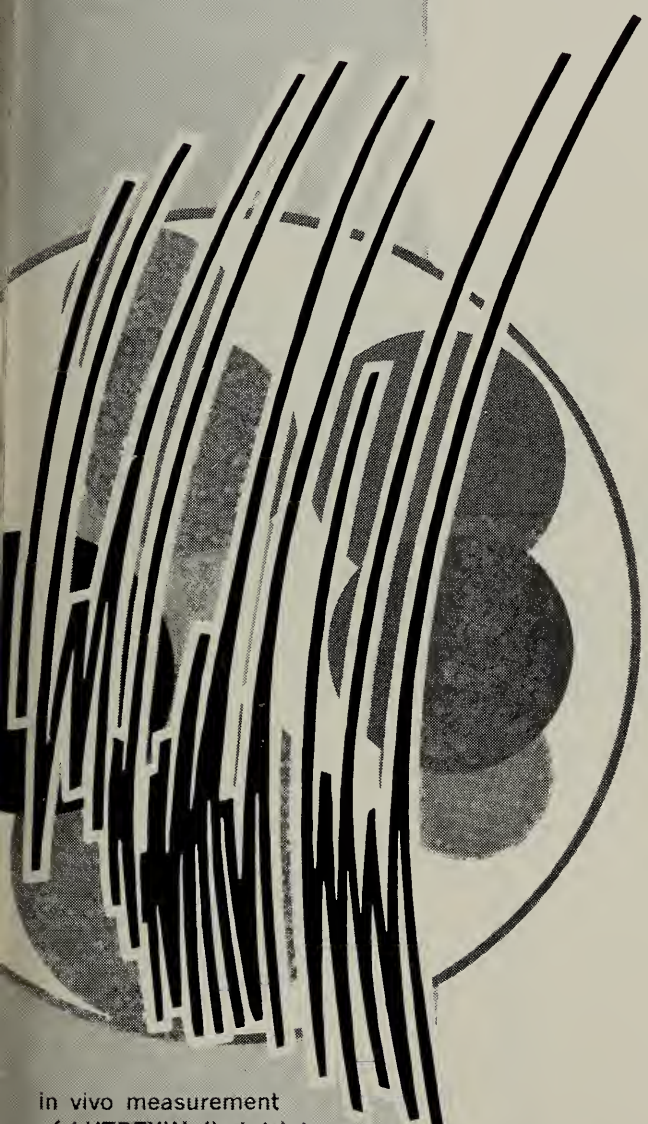
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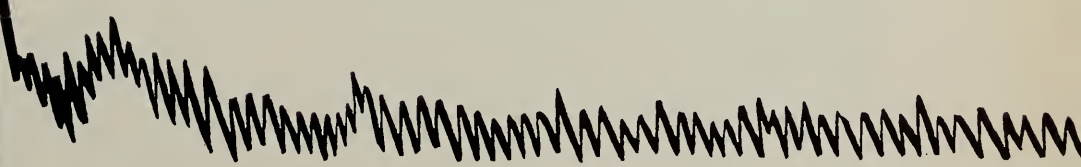
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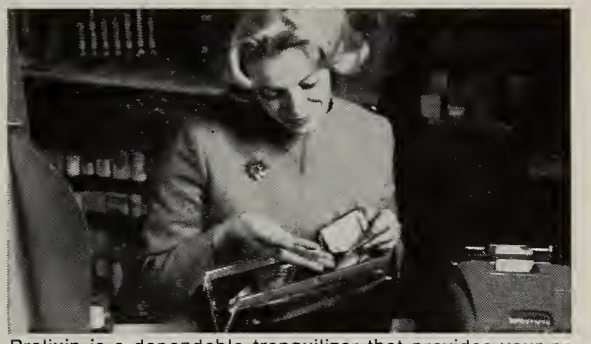
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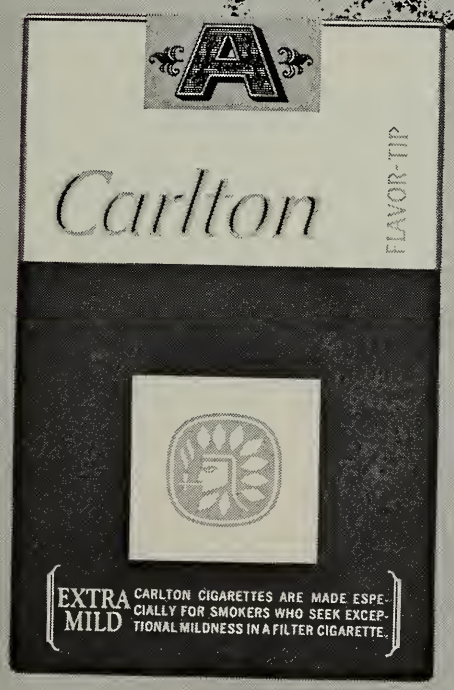
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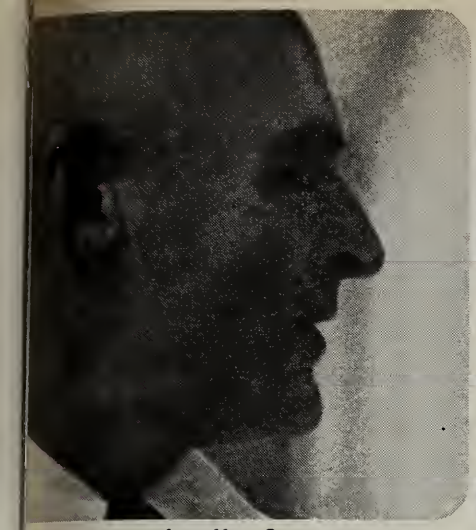
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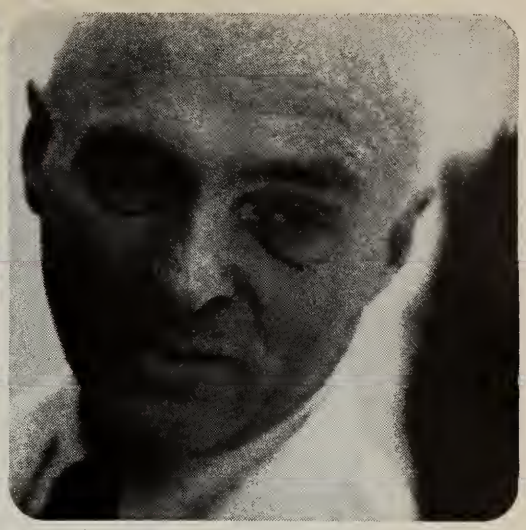
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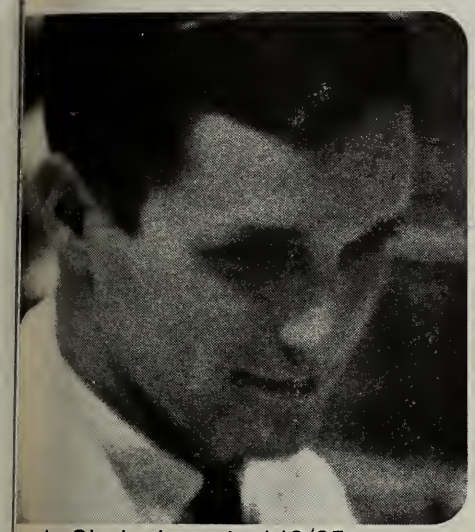
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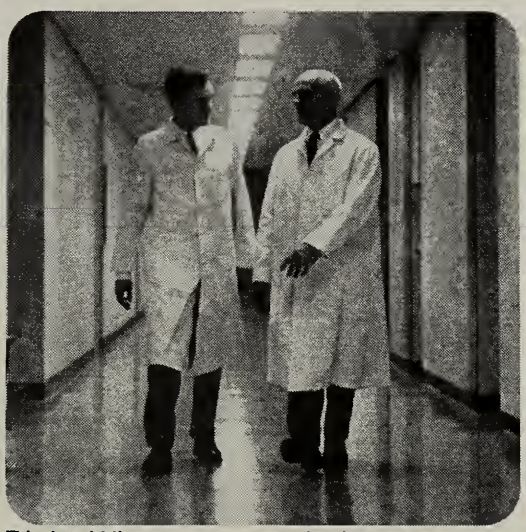
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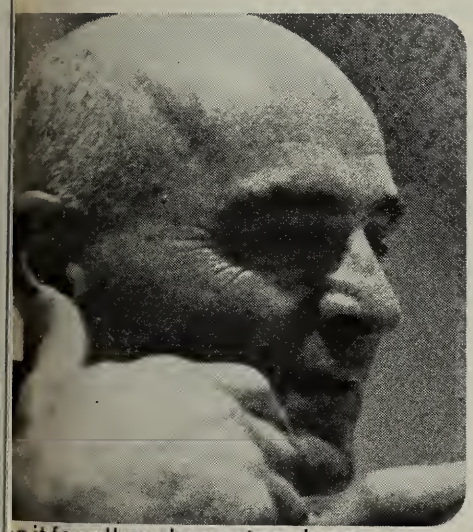
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Right. When we started, she was 195/120.



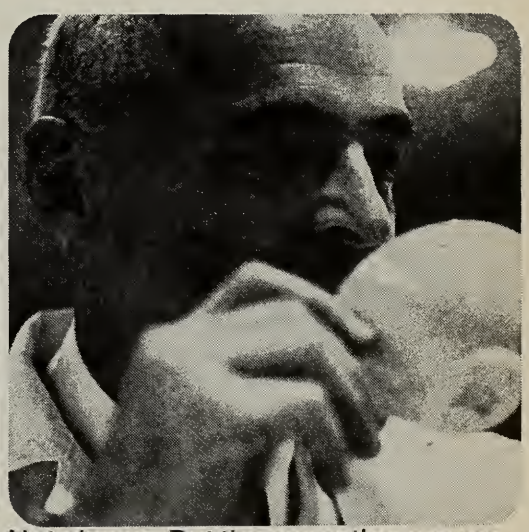
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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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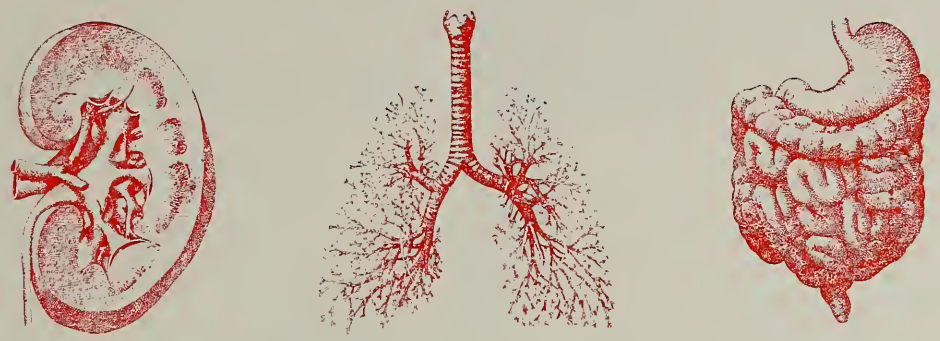
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*Dosage:* Adults—250 mg. every six hours in respiratory infections; 500 mg. every six hours in urinary and gastrointestinal infections (higher doses may be needed in severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours; 200 mg./Kg./day in divided doses every six hours for severe infections.

*Contraindications:* (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes, Pseudomonas pyocyanea,* and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

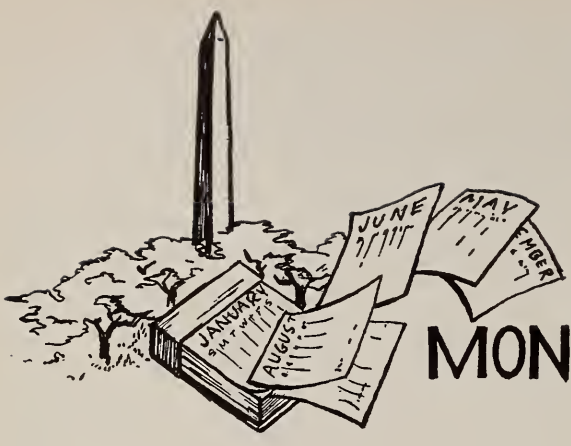
*Side Effects:* Mild effects, such as skin rashes, diarrhea, nausea and vomiting have occasionally appeared.

*Precautions:* As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

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*References:* 1. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 2. Editorial. Lancet *ii*:723 (Oct. 5) 1963. 3. Parker, M. T., *et al.:* Brit. M. J. *i*:1550, 1962. 4. Evans, W., and Hansman, D.: Lancet *i*:451 (Feb. 23) 1963. 5. Richards, J. D. M., and Rycroft, J. A.: Lancet *i*:553 (March 9) 1963. 6. Schaedler, R. W., *et al.:* New England J. Med. *270*:127 (Jan. 16) 1964. 7. Howard, P., and Riley, H. D., Jr.: Abstracts, Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, Oct. 26-28, 1964, New York, N.Y.

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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D. C.—The American Medical Association has urged that Congress approve the Herlong-Curtis Eldercare bill (H.R. 3727) as the best answer to the problem of providing medical care to people over 65 who need help in paying hospital and doctor bills.

In testimony presented at a closed hearing of the House Ways and Means Committee, representatives of the AMA also reaffirmed the association's opposition to the King-Anderson bill, known as Medicare.

The Herlong-Curtis Eldercare bill, incorporating recommendations of the AMA, was introduced by Rep. A. Sydney Herlong, Jr., (D-Fla.) and Rep. Thomas B. Curtis (R., Mo.).

The AMA was represented before the House Committee by Donovan F. Ward, M.D., Dubuque, Iowa, the association's president; F.J.L. Blasingame, M.D., AMA executive vice-president and Frank Coleman, M.D., Des Moines, Iowa, past chairman of the AMA Council on Legislative Activities.

The bi-partisan Herlong-Curtis bill, entitled the Eldercare Act of 1965, would amend the Kerr-Mills law to authorize broad health insurance coverage for elderly persons. It would authorize federal grants to the states on a matching basis to help persons 65 years of age and older pay costs of the health insurance if they could not afford it otherwise. The bill would provide for utilization of Blue Shield and Blue Cross plans and private health insurance companies.

The cost of such coverage would be borne entirely by the government for those elderly individuals whose income falls below limits set by each state. For individuals with incomes between the minimum and a maximum, government would pay a part of the cost on a sliding scale according to income. Individuals with income above the maximum would pay the entire cost, but they would have the benefits of an income tax deduction for such payments, as well as statewide bargaining for non-cancellable health care policies.

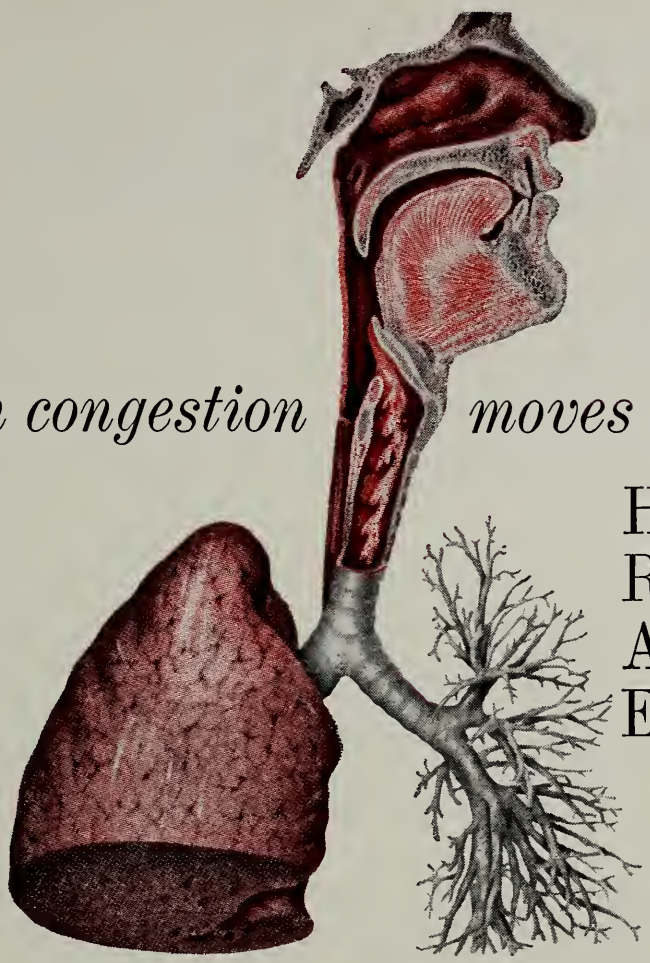
Persons under 65 years of age also would be given an income tax deduction for the amount of premiums paid on non-cancellable health insurance policies to become effective upon retirement.

States could administer the program under state health departments if they so choose. The Kerr-Mills program now is administered by state welfare departments.

Both Herlong and Curtis are members of the Ways and Means Committee which made health-care-for-the-elderly legislation its first business of this session.

In a joint statement when they introduced the bill, Herlong and Curtis said:

"Our legislation is designed to provide elderly persons all the medical



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**CAUTION:** Should be used with caution in patients with known idiosyncrasies to phenylephrine hydrochloride and in those with moderate or severe hypertension, hyperthyroidism or advanced arteriosclerosis. In these patients the use should not exceed three days. Hycomine* Syrup is generally well tolerated but in some patients drowsiness, dizziness or nausea may occur.

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services they require, in contrast to the limited benefits in the King-Anderson Social Security tax bill. Under our bill, workers would not be taxed to pay for hospitalization of those who are financially able to pay for it themselves.

"This legislation would not endanger the solvency of the Social Security fund or permit control of local hospitals by a federal bureaucracy, as the King-Anderson proposal could.

"This bill goes to the real problem: helping those who need help in financing their health care. That problem would still remain after these individuals had used up the limited benefits of the King-Anderson bill. Why levy a new tax and set up another federal bureaucracy when it will not do the full job?"

Identical bills were introduced by a number of senators and other members of the House, including Rep. Durward G. Hall (R., Mo.), who also is a member of the AMA House of Delegates.

The AMA representatives pointed out that the Eldercare bill was designed to provide the elderly who need financial assistance with a wide range of hospital and medical benefits—far more than the limited benefits Medicare would provide.

Under the Herlong-Curtis Eldercare bill, the amount of financial assistance given to the elderly would be determined by the amount of help required, the AMA noted.

The Eldercare plan would expand and enlarge on the existing Kerr-Mills law, preserving state control over administration and requiring no new payroll taxes on wage earners, the AMA said.

They pointed out that Medicare benefits would be restricted to limited hospitalization, some nursing home care in some nursing homes, some hospital-connected diagnostic services and home nursing care.

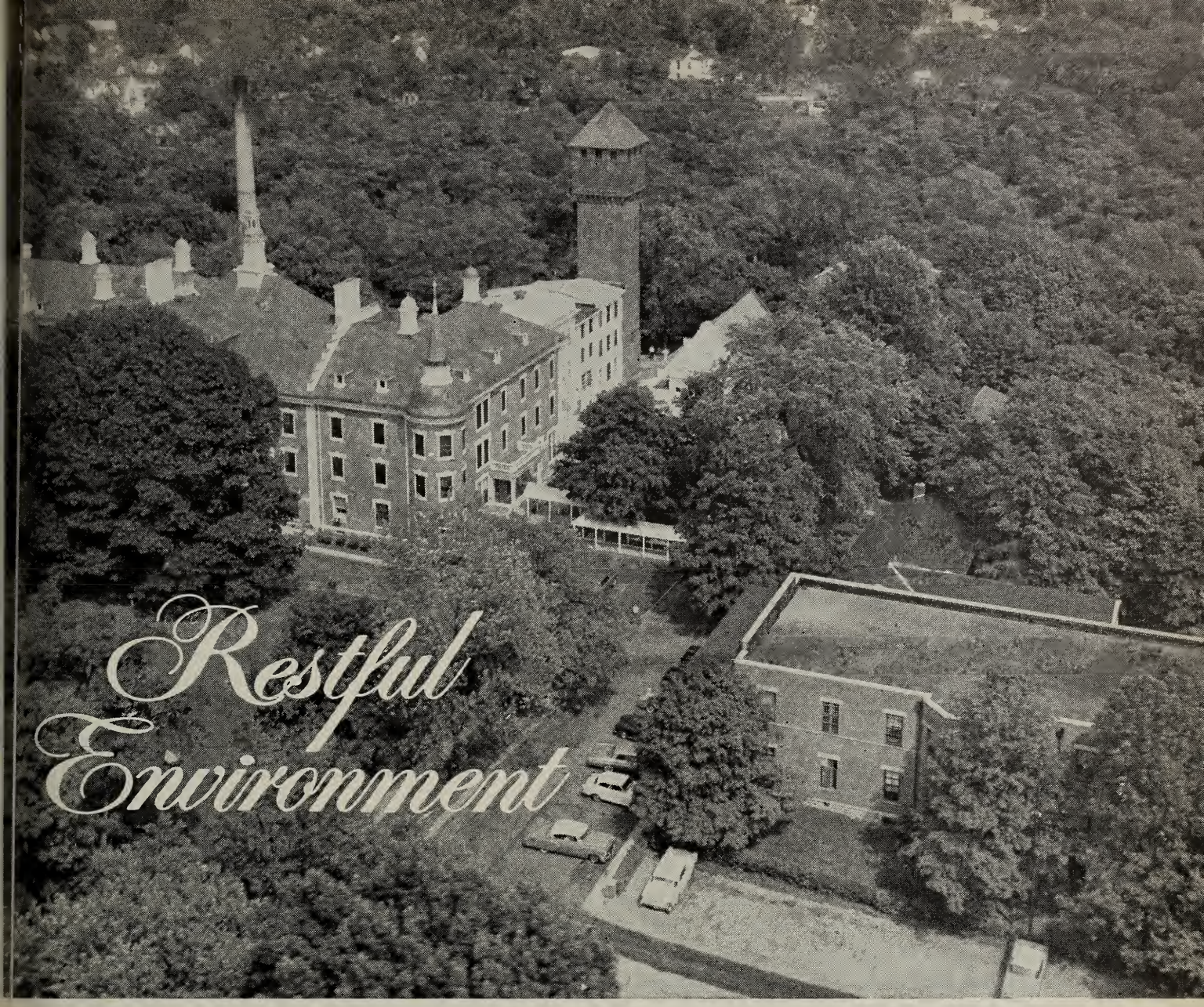
They said all these benefits would be provided under the Eldercare program. But in addition, they said, Eldercare would provide the services of physicians and surgeons, drugs outside the hospital as well as in the hospital, diagnostic services whether connected to hospitalization or not and other medical services which Medicare would not provide.

They also pointed out that Medicare would impose higher payroll taxes on workers and employers for a centralized, federally-controlled program which would provide benefits to everyone over 65, the wealthy and well-off as well as the needy.

At the request of the Johnson Administration, which is pushing the King-Anderson medicare legislation, Rep. Wilbur D. Mills (D., Ark.), chairman of the Ways and Means committee, introduced a sweeping bill (H.R. 3699) that would consolidate the federal-state medical programs and extend Kerr-Mills medical benefits to needy children under 21 years of age and their parents.

The Administration bill also would require states to follow a flexible income test to determine Kerr-Mills eligibility and to provide specified minimum medical services. These minimum services would include inpatient and outpatient hospital services, other laboratory and x-ray services, nursing home care and physicians' services "in the (physician's) office, the patient's home, a hospital or a skilled nursing home."

Dr. Ward told the Ways and Means Committee that the AMA opposes the King-




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Continued

Anderson medicare bill (H.R.1) because it "would be unpredictably expensive."

"It is unnecessary," he said. "It would represent a dangerous venture by the federal government in the field of health care.

"Enactment of this program would impose an unfair burden on the nation's wage-earners and their employers to finance health care benefits for millions of older Americans who are self-supporting, even wealthy, and do not need government benefits.

"Further, government regulation and control which would be established under this bill is not compatible with good medicine. The availability of medical service to the aged could be contingent upon the availability of tax money and not upon the medical needs of older citizens. With quantity thus restricted, quality would inevitably suffer . . . .

"We are opposed to government undercutting and disrupting the continuing progress of private health insurance and prepayment plans, on which 145,000,000 Americans of all ages today depend for protection from their illness costs.

"We are opposed to offering false promises to the unfortunate who do need help. This bill would provide only a fraction of the care necessary in any serious illness, a fact which many of our aged do not realize. . . .

"From the beginning, our involvement in this issue has been deep and unavoidable. We physicians care for the elderly and know their health needs better than anyone else. . . .

"We have pursued for years the goal of finding a means for filling the broad medical needs of older citizens, who need help in financing their health care, while preserving for all Americans the high standards and high quality of our present health care system.

"Out of these efforts of the nation's physicians—during which they examined and rejected scores of tentative proposals—has come a series of recommendations which has found expression in H.R. 3727.

"I say categorically that this bill could provide more benefits for persons over 65 who need health care and cannot pay for it, and at less cost to taxpayers, than any other measure pending before Congress. . . .

"Utilizing Blue Cross and Blue Shield and health insurance companies as intermediaries, state governments would be authorized to offer the aged a broad spectrum of benefits, including physicians' care, surgical and drug costs, hospital and nursing home charges, diagnostic services, and x-ray and laboratory fees. These are the components which go to make up an individual's total bill for illness.

"H.R.1 would cover only a small portion of these services. . . . It would not cover doctors' services or surgical charges. It would not cover drugs outside the hospital or nursing home. It would offer only a partial answer to any serious illness." ◄



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*Morador, J. L. et al.: Antibiot. Ann. 1959-1960:716.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Abscesses, various | 35 | 34 |
| Abscess, gluteal or perianal | 54 | 52 |
| Burns, infected | 331 | 307 |
| Carbuncles and furuncles | 125 | 122 |
| Cellulitis | 104 | 102 |
| Lacerations and wounds, infected | 142 | 128 |
| Ulcers, infected | 107 | 106 |
| Various superficial infections | 190 | 185 |
| Totals | 1,088 | 1,036 (95.2%) |

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| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Ear, nose and throat infections | 507 | 465 |
| Respiratory infections | 1,028 | 954 |
| Gastrointestinal infections | 425 | 387 |
| Genitourinary infections | 748 | 684 |
| Skin and soft-tissue infections | 1,088 | 1,036 |
| Bone and joint infections | 71 | 64 |
| Deep-seated or generalized infections | 257 | 251 |
| Obstetrical & gynecological infections | 341 | 320 |
| Miscellaneous conditions | 592 | 570 |
| Totals | 5,057 | 4,731 (93.5%) |

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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## To Care For The Elderly

If Congress insists that a new kind of medical care program for the elderly is needed, it will be offered some alternatives to the Johnson administration's medicare proposal.

The American Medical Association has proposed a plan to use private medical and hospital care insurance policies. Persons over 65 would be entitled to part or full assistance in paying the premiums, on the basis of their individual financial situations. Eligibility would be determined on the basis of an income statement, with no welfare investigation involved.

Welfare departments would not even enter the picture under the AMA proposal. Applications and assistance payments would be handled through state health departments. Federal and state funds would be used for the payments.

The AMA argues that this plan would protect existing medical, hospital and insurance systems. It would offer the individual much broader protection than is proposed for medicare, which would cover only hospital and nursing home costs within certain limits. The individual would have the advantage of determining eligibility and acquiring protection before illness occurs. The Social Security system would not be involved.

Another proposal is being drafted by a group of Republicans in Congress. It also would use private insurance plans, but would pay for them at least partly through the Social Security system. It would provide an increase in cash benefits to all Social Security recipients, to be used in part to pay the insurance premiums. The individual payment would be on a sliding scale related to his regular monthly benefit payments. The rest of the policy cost would come from Federal subsidy.

The chief objection to involving the Social Security system, especially in a plan of direct government payment for hospital or other medical costs, is that the costs are unpredictable and could easily rise to such heights that they would imperil Social Security.

One great disadvantage of any system of direct government payments is that it would almost certainly involve the creation of a new government bureaucracy, which would add its costs to the costs of medical care.

Both of these pitfalls would be avoided under the AMA proposal. It should be seriously considered.—*The Indianapolis Star*, Jan. 26, 1965.

## Congress, The AMA And Medicare

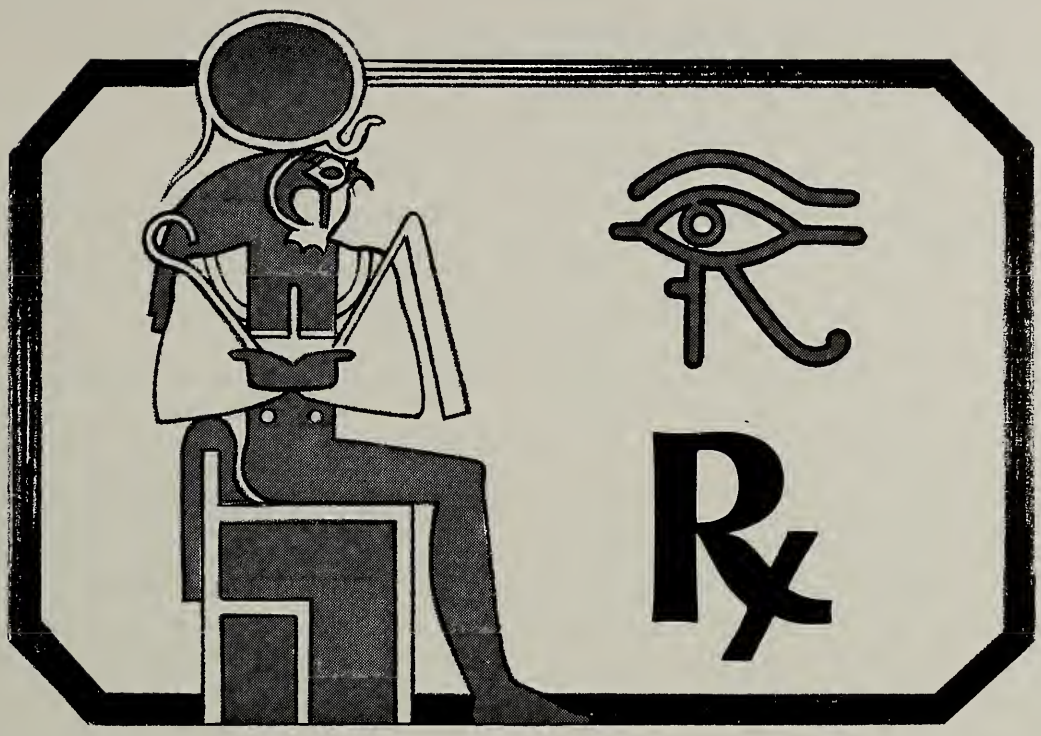
Some form of legislation extending medical care benefits to persons aged 65 and over will almost certainly be approved in the present session of Congress.

What remains to be determined—and it is an all-important factor—is the scope and methods of financing required to achieve the most desirable and sound program possible.

More than 17 million U.S. citizens are today aged 65 or older, and this number is rising rapidly. Thanks to modern medicine and improved environmental conditions, a person who reaches the age of 65 can reasonably expect to celebrate his 80th birthday.

This age group, at the same time, is most

Continued




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subject to heavy medical expenses, and the cost of medical care has climbed more steeply in recent years than any other major commodity figured in the consumer price index. An average couple 65 or over spends more than $300 a year on medical needs, exclusive of hospitalization. The typical elderly person, meanwhile, has a 13% chance of being hospitalized in a given year.

One method for dealing with the medical needs of the aged, beyond the traditional uses of individual resources and private insurance, was launched in 1960 when Congress passed the Kerr-Mills Act. This provides for Federal part-payment to those states which set up programs to offer medical help to the needy elderly.

Forty states now participate in Kerr-Mills. The individual programs, however, vary greatly both in scope and in eligibility requirements. The most often-heard criticisms of Kerr-Mills are, first, that in most participating states too little is provided for those eligible and, second, that few persons other than the indigent can benefit.

The American Medical Association, a major foe of the administration's medicare plan for hospital and nursing home care for the aged, has announced a "redefinition" of its policy on Kerr-Mills, which it has heretofore staunchly supported in its present form.

Kerr-Mills, under the new AMA proposal, would be retained but with major modifications. Persons over 65 would purchase some form of commercial health insurance, paying all or none of the cost according to their incomes, not according to their assets as some states now require. For those with incomes below an as yet unspecified level, the state would pay, using its own and Federal funds.

The AMA plan is for complete comprehensive coverage, unlike medicare. It would be financed through general revenues, rather than an increased Social Security tax. It would utilize experienced private insurance carriers and existing Kerr-Mills machinery, thus obviating the need for a separate administering Federal bureaucracy.

This plan is but one of several alternatives to medicare Congress should study carefully before writing its own bill. Financial soundness and its impact on the U.S. economy, as well as moral intent, must be considered in any medical care for the aged legislation—From the *Los Angeles Times*, reprinted in *The Indianapolis Star*, Jan. 26, 1965. ◄

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**To My Patients . . .**

## *Now - I Need Your Help*

**The new Congress plans to socialize my practice by first enacting a Medicare program for the aged.**

**The next step will be socialized medical care for citizens of all ages because younger people are not going to be satisfied with being taxed to pay for benefits of the aged and not receive benefits of their own.**

**Ultimately, this will lead to a complete program of socialized medicine with inferior care for you—just as it has in other countries—and a regimented, government controlled practice for me.**

**You can help me to continue to take care of you in the best way possible by writing your opposition to Medicare to your Representative and two Senators—AT ONCE! You will be on sound ground in doing this because there are already provisions at state and local levels for furnishing medical care to the needy aged.**

## *Won't You Help Me - Now?*

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# The Phonocardiogram and External Pulse Tracings

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*Indianapolis**

PHONOCARDIOGRAPHY, the graphic recording of cardiovascular sound, has come to play an increasingly important role in clinical medicine in recent years.[1,2] The use of this method has virtually revolutionized the field of cardiac auscultation, pointing the way toward heretofore undetected physical findings and furnishing a new medium for gaining information not otherwise obtainable.

It is thus incumbent upon all physicians to have at least a cursory acquaintance with its uses, limitations, configuration and ancillary reference systems. We have listed a group of selected examples here with the intention of helping the clinician appreciate the use of this valuable technique, and, in the process, to gain a greater understanding of what he hears at the bedside.

* From the Department of Medicine (Division of Cardiology) and the Heart Research Center, Indiana University School of Medicine and the Krannert Heart Research Institute, Marion County General Hospital, Indianapolis.

Supported by the Herman C. Krannert Fund, the Indiana Heart Association, Indiana State Board of Health and (in part) by the U. S. Public Health Service Training Grant 5363 and (in part) with facilities provided by Cardiovascular Clinical Research Center Grant H-6308 from the National Heart Institute, National Institutes of Health, U. S. Public Health Service.

Dr. Tavel is a former trainee of the National Heart Institute; Present address: 1815 N. Capitol Ave., Indianapolis.

## Materials and Methods

Sounds are recorded in all major areas of auscultation and frequently are recorded from two areas simultaneously (most often, the pulmonic area and the apex). Pulses are recorded from over the carotid artery, the precordium and the jugular vein.

The electrocardiogram (Lead II), microphones and pulse-sensing devices are connected to a multi-channel recorder (Electronics for Medicine) and registered on the oscilloscopic screen. The image also is recorded photographically with a rapid-developing process, generally with a paper speed of 75-100 mm. per second and time lines at 0.1-second intervals.

*The phonocardiogram* is a recording of heart sounds, made with a microphone placed on the surface of the chest. Its teaching function is of extremely great value, for it allows us to check carefully and analyze what we hear by auscultation. The phonocardiogram also makes possible the accurate timing of sounds and events which are often too subtle to be discerned at the bedside. This technique is not, however, a substitute for the human ear, which generally is far more sensitive and discriminating; indeed, although many murmurs can be accurately characterized, the phonocardiogram occasionally fails completely to record certain sounds, such as a soft, high-pitched murmur of aortic insufficiency, which is

easily heard by the clinician.

*The carotid pulse tracing* is a measure of the contour of the carotid pulse, recorded by a sensing device held against the neck, directly overlying the carotid pulsations. It also may be recorded by placing a narrow blood-pressure cuff around the neck, inflating it to low pressure (15-20 mm. Hg.) and recording pressure changes from within the cuff. The carotid tracing begins to rise with aortic ejection and reaches its peak at the time of maximum ejection (Figure 19).

When recorded in conjunction with the phonocardiogram, the carotid pulse tracing supplies an excellent means to localize the aortic closure sound (A2), since the dicrotic notch coincides with this sound. The carotid tracing also is of assistance in the diagnosis of aortic stenosis, for with this valvular deformity there is usually a slow rise in the ascending limb, often with an anacrotic notch and a prolonged ejection time. The ejection time is that distance from the beginning of the upstroke to the dicrotic notch.

*The apexcardiogram*[3] is a recording of the pulsations over the precordium at the point of maximal impulse. This recording is made with an apparatus similar to that used in carotid pulse tracing. The tracing shows an elevation with atrial contraction, another abrupt elevation with the onset of ventricular contraction, a peak with beginning ventricular ejection and finally a sharp downward angulation at the time of mitral valve opening. Shortly thereafter, it rises again rather abruptly and thus identifies the period of rapid early diastolic ventricular filling (Figure 5). When recorded in conjunction with the phonocardiogram, the apexcardiogram is especially useful in localizing and differentiating the opening snap and the third heart sound.

*The jugular venous tracing*[4] is a record of volume changes within the jugular vein sensed by a cup-like device applied to the surface of the skin, directly overlying the jugular vein. It is useful in the timing of atrial systole and the detection of increased backflow of blood during right atrial contraction, as seen with tricuspid stenosis or complete heart block when atrial and ventricular systole coincide. The recording of jugular pulsations is also valuable in detecting tricuspid regurgitation, characterized by prominent "V" waves. The use of the jugular pulse recording is of some additional assistance as a reference for phonocardiography in that it aids in the differentiation between right and left ventricular protodiastolic gallops and, to a limited extent, between mitral and tricuspid valve opening snaps.

### The Normal Phonocardiogram

Figure 1 is a record taken from a normal subject, showing the ECG, together with sound tracings over the pulmonic and apical areas. S1 and S2 are the first and second heart sounds, respectively. S1 begins about 0.05 seconds after the beginning of the QRS complex on the ECG. S1 is split into two major components: the first due to mitral closure and the second to tricuspid closure. S2 is also split into two components: aortic valve closure (A2), followed by pulmonic valve closure (P2). In the normal individual, P2 is soft with little radiation, is maximal in the pulmonic area and cannot be identified at the apex. Normally, as shown in this tracing, only A2 is seen clearly at the apex. If one hears two components of the second sound at the apex (and an opening snap is known to be absent) then P2 is abnormally loud and this finding suggests pulmonary hypertension.

Figure 2 exemplifies the normal relationship between the splitting of S2 and

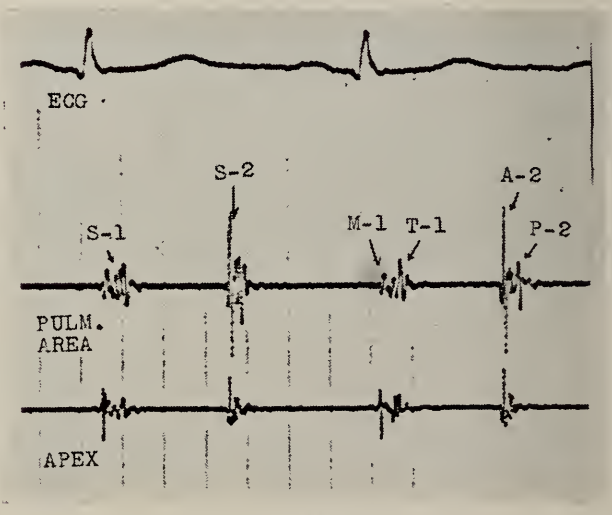



FIGURE 1

SOUNDS RECORDED from the pulmonic area and apex of a normal subject. S1=First heart sound; M1=Mitral valve closure; T1=Tricuspid valve closure; S2=Second heart sound; A2=Aortic valve closure and P2=Pulmonic valve closure.

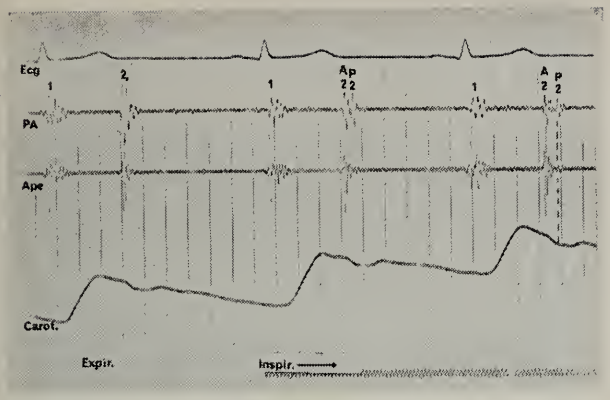



FIGURE 2
RESPIRATORY effect on heart sounds, and relationship between second sound components and carotid pulse in a normal subject. In the complex on the far right, P2 falls almost directly on the dicrotic notch (stippled line).

respiration. During expiration, splitting is minimal or absent (normal less than 0.04 seconds) and with inspiration, the splitting becomes greater, primarily because of delay of P2. This delay is caused by transient prolongation of right ventricular contraction consequent to increased filling on inspiration. In addition, the relationship of A2 and P2 to the carotid dicrotic notch can clearly be seen. Owing to a slight pulse delay in the arterial system, the dicrotic notch normally follows A2. This delay is fixed and constant in each patient, amounting to about 0.03 seconds. On the other hand, P2 may fall before, during or after the dicrotic notch, varying its relationship with respiration—a fact which often serves to distinguish it from A2.

## Abnormalities of the Second Heart Sound

*Fixed splitting*: Figure 3 is an example of a widely-split second sound in which the interval between A2 and P2 does not vary significantly with the respiratory cycle, remaining long during expiration. This record was taken from a patient with atrial septal defect and is typical for this lesion.

Why such fixation of splitting should occur remains controversial but the most plausible explanation is as follows: the left-to-right atrial shunt, by maintaining a high right ventricular inflow during expiration, precludes the normal shortening of mechanical right ventricular systole during this phase of respiration, thus insuring that P2, likewise, will be continuously late. The right ventricle, already greatly stressed, is unable to further augment its duration of systole during the inspiratory phase.

Other conditions which can cause a delay in P2 with wide splitting of the second sound are right-bundle-branch-block or pulmonic stenosis, but these do not ordinarily disturb the normal variations of the A2-P2 interval with respiration, unless congestive failure is also present.

*Paradoxical splitting*: The sound tracing in Figure 4 shows "paradoxical splitting" of the second sound. In certain disease states where aortic valve closure is delayed[5] (left-bundle-branch-block, aortic stenosis, systemic hypertension, patent ductus arteriosus), the aortic valve may actually close *after* the pulmonic, reversing the normal sequence of events. In such circumstances, when pulmonic closure is delayed with inspiration, the splitting will narrow instead of widening. Note that the sound tracing over the apex enables one to locate




FIGURE 3
ATRIAL SEPTAL DEFECT with wide "fixed splitting" of S2. Also present are a systolic ejection click (EC) and ejection murmur (SM).

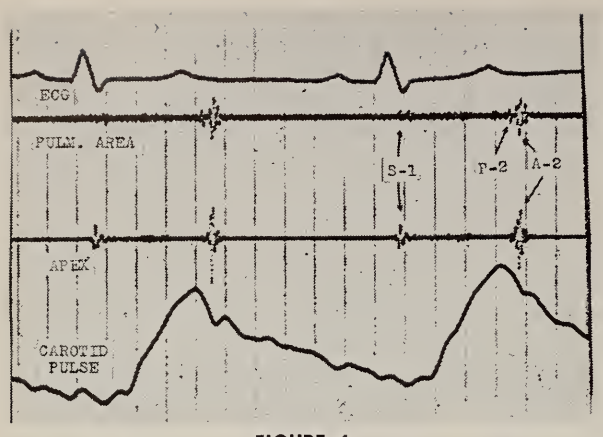



FIGURE 4
LEFT-BUNDLE-BRANCH-BLOCK with "paradoxical splitting" of S2.

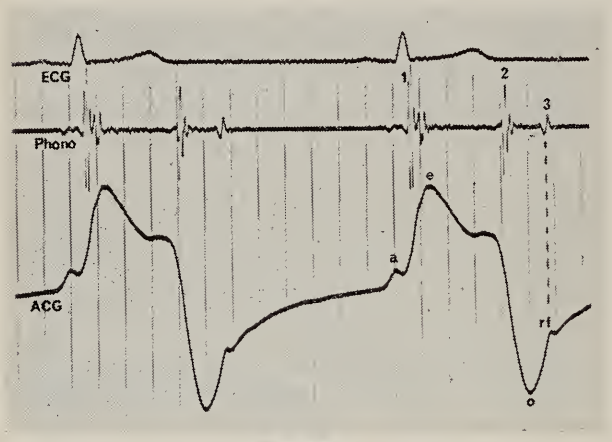



FIGURE 5
NORMAL youth with third heart sound (3). Normal apexcardiogram; a =atrial contraction; e=beginning of ventricular ejection; o=opening of mitral valve and rf=rapid filling phase of ventricle.

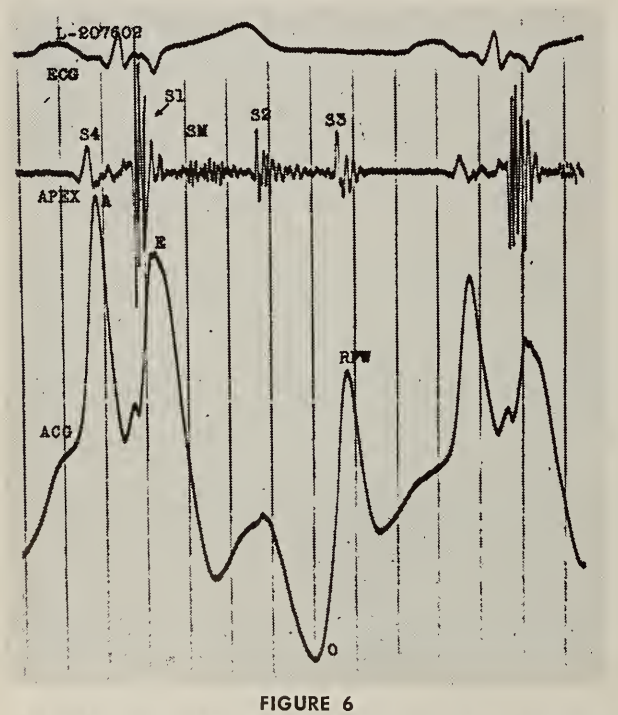



FIGURE 6
PRIMARY MYOCARDIAL DISEASE with left ventricular hypertrophy; third and fourth heart sounds (S3 and S4) are present. Systolic ejection murmur (SM) is present. Apexcardiogram shows large A wave.

the aortic closure, which can then be identified in the pulmonic area as the last component of the second sound.

### Third Heart Sound

The tracing in Figure 5 came from a normal youth and displays a prominent early diastolic filling sound, commonly referred to as the third heart sound (S3). Although frequently occurring in the normal child or young adult, when seen in congestive heart failure this sound is designated as a "protodiastolic gallop." Below the phonocardiogram is an apexcardiogram which shows the relationship between the rapid-filling (rf) wave and S3. The other major deflections on the apexcardiogram are atrial contraction (a), beginning of ventricular ejection (e) and opening of the mitral valve (o).

### Fourth Heart Sound

Figure 6 exemplifies the fourth heart sound (S4), which is synchronous with atrial contraction. In the normal individual, it is usually not heard, but if the P-R interval is prolonged, or if the atrium contracts with increased force, as in systemic hypertension or left ventricular hypertrophy, the fourth heart sound may become audible. When it occurs in these pathological states, the fourth heart sound is sometimes called an "atrial gallop" or "presystolic gallop." This tracing was taken from a patient with primary myocardial disease and left ventricular hypertrophy, and, in addition to a fourth heart sound, there is a protodiastolic gallop (S3). Note that the fourth sound coincides with a large A wave in the apexcardiogram which is probably caused by forceful left atrial contraction.

### Opening Snap

The tracing in Figure 7 is taken from a patient with mitral stenosis and clearly shows an opening snap. The snap corresponds in time with the "o" point on the apexcardiogram, located just beneath it. The interval between A2 and the opening snap can differ greatly from patient to patient: from 0.03 to 0.12 seconds. The interval in the tracing in Figure 7 is about 0.06 seconds. The opening snap often is confused with normal splitting of the second sound, inasmuch as the latter normally can

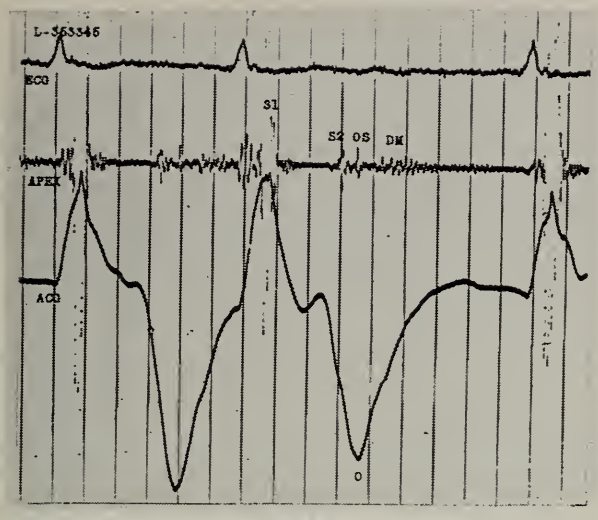



FIGURE 7
MITRAL STENOSIS with opening snap (OS) and diastolic murmur (DM).

reach 0.08 seconds or longer with inspiration. The interval between A2 and the opening snap, however, does not vary significantly with respiration. In addition, the opening snap is usually heard best at the lower left sternal border or inside the apex, whereas the split second sound is heard most clearly at the pulmonic area. Perhaps the best way to differentiate the opening snap from pulmonic closure is by demonstrating all three components on inspiration, i.e., A2, P2 and the snap (Figure 17).

On the other hand, the opening snap occurs earlier than the third heart sound (not present in Figure 7), the latter generally occurring from 0.10 to 0.20 seconds after the onset of the second sound. The opening snap in Figure 7 can be differentiated from a third heart sound by the fact that it occurs somewhat early (after S2—0.06 seconds) and that it coincides with the "o" point on the apexcardiogram rather than with the following rapid-filling wave.

Also, in the phonocardiogram in Figure 7, a mitral diastolic murmur can be seen which will be discussed later.

### Ejection Click

Figure 8 exemplifies the ejection click (EC). (See also Figures 3, 9 and 11). It is taken from a patient with an atrial septal defect and pulmonary hypertension. This sound occurs shortly after the first heart sound, at the time of opening of the pulmonic or aortic valve, and is believed to be related to dilatation of the pulmonary artery or aorta (pulmonary artery in Figure 8). This dilatation can be due to either valvular stenosis or hypertension within the vessel. The ejection click from the right heart resembles late tricuspid valve closure (as seen occasionally in right-bundle-branch-block) but it is usually maximal at the base. On the other hand, ejection clicks from the left side of the heart are more difficult to identify, since they occur earlier in systole, falling very near tricuspid closure and are transmitted well to the apex, a place where splitting of the first heart sound normally can be heard. The time interval between the onset of mitral or tricuspid valve closure and the respective left-or-right-sided ejection click varies with the pressure distal to the semilunar valve concerned. Thus, the interval between tricuspid closure and the ejection click is long in pulmonary hypertension and short in pulmonic stenosis.

### Systolic Murmurs

Figure 9 demonstrates a typical systolic ejection murmur, emanating in this case from the aortic area. This type of murmur

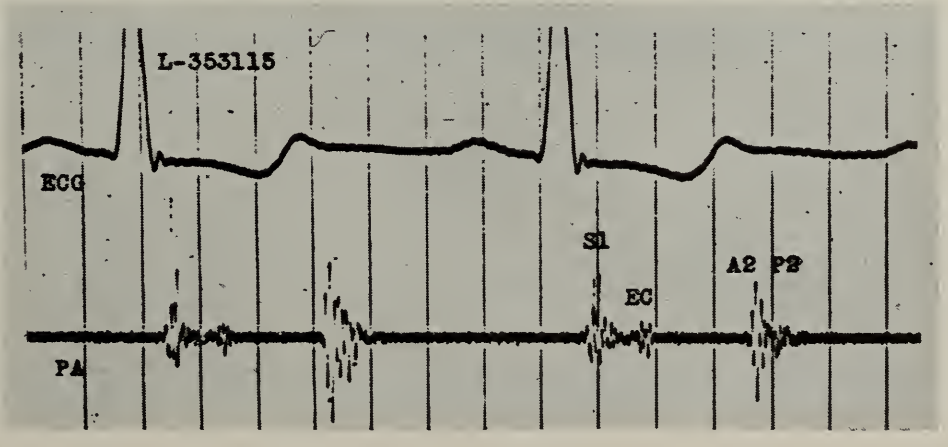



FIGURE 8
ATRIAL SEPTAL DEFECT with ejection click (EC).

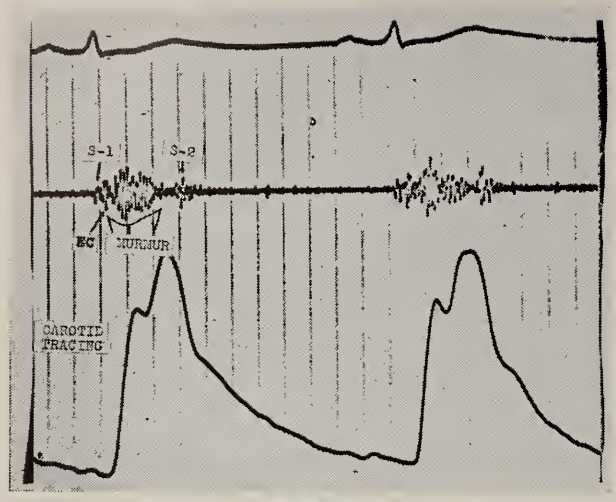



**FIGURE 9**
**DILATATION OF AORTA with systolic ejection murmur.**

parallels ejection of blood through the pulmonic or aortic valves, beginning with opening of the valve, reaching its maximum intensity in mid-systole at the time of maximum flow and tapering off just before closure of the same respective valve. Such a flow pattern imparts to this murmur its typical "diamond-shaped" configuration. This type of murmur may be due to valvular or infundibular stenosis, valvular damage without stenosis, dilatation of the vessel beyond the valve, increased flow through the valve or combinations of the above factors. In the case represented by Figure 9, the murmur was believed to be attributable to dilatation of the aorta beyond the valve. In such cases, where valvular stenosis is lacking, aortic flow reaches its maximum early in systole, thus causing the murmur to reach its maximum intensity and to taper off somewhat early as well. The murmur in this example begins with a prominent sound, believed to be an ejection click.

Figure 10 is another example of an aortic systolic ejection murmur. In this case, however, the murmur was caused by valvular stenosis. Note that it is nearly identical to the previous murmur except that its peak and disappearance occur somewhat later in the cycle. This delay is caused by retardation of blood flow across the stenotic valve.

Figure 11 is a tracing from a case of pulmonic stenosis, with sounds recorded from the pulmonic area and apex. In the pulmonic area (PA), one can see a prolonged systolic ejection murmur, which begins with an ejection click (X). There is a soft, late P2 which causes wide splitting of the second sound. Note that P2 falls after the carotid dicrotic notch, clearly differentiating it from A2 in this case. The simultaneous tracing taken from the apex also helps to identify the location of A2. One should note that the ejection murmur continues through A2, demonstrating the rule that, while ejection murmurs end before the component of the second sound formed by closure of the semilunar valve on the same side, they may not pay such respect to closure sounds originating on the opposite side. This can cause confusion at the bedside, inasmuch as such a murmur may sound as if it continues through "the second sound" and thus may be labeled a "pansystolic" murmur (see below).

Another example of a pulmonic systolic ejection murmur can be seen in Figure 3, where the murmur is caused by voluminous blood-flow through the pulmonic valve in a

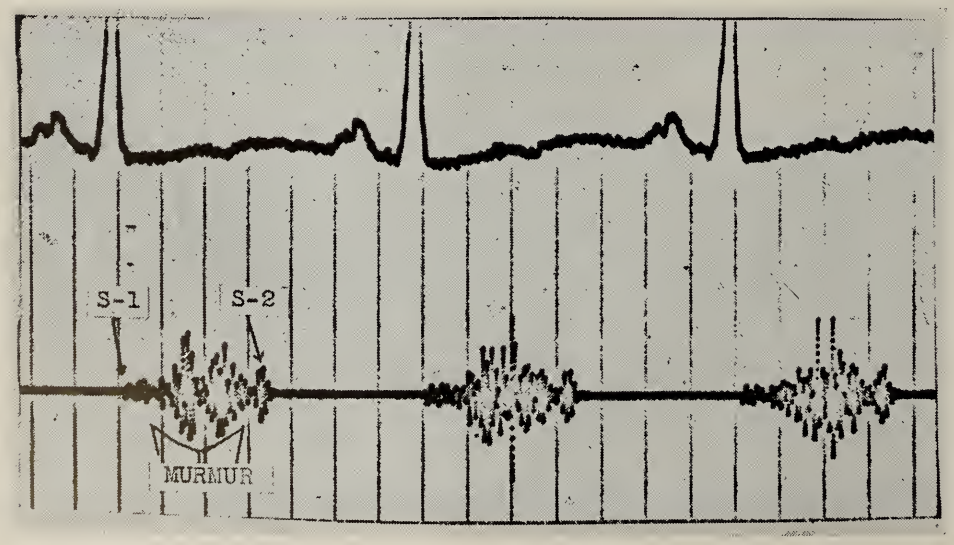



**FIGURE 10**
**AORTIC STENOSIS with systolic ejection murmur.**

patient with atrial septal defect.

### Regurgitant Murmurs

Figure 12 shows a typical "pansystolic" or "regurgitant" murmur in a patient with isolated mitral insufficiency. The murmur begins immediately after the first sound and continues through all of systole with relatively even intensity, ending with, or shortly after, A2. Because of the continuation of the murmur through both components of the second sound, it is often difficult to identify this sound.

One can see, also, in this record what was identified as a left ventricular third heart sound, again coinciding with the rapid-filling wave on the apexcardiogram. The presence of this sound indicates that this ventricle is filling rapidly in early diastole. Occurrence of such a sound in mixed mitral valve disease is, therefore, good evidence that insufficiency is the predominant deformity and that stenosis cannot be severe.

This tracing exemplifies another feature sometimes seen in mitral insufficiency, namely, wide splitting of the second sound. Because the left ventricle is decompressing itself into the left atrium during systole, the actual duration of left ventricular ejection into the higher pressure aorta is shorter. Thus, A2 occurs earlier than normal in the cycle and farther away from P2.

Figure 13 shows another example of a pansystolic murmur in a tracing taken from a patient with a ventricular septal defect with left-to-right shunting of blood. The tracing over the apex is typically pansystolic, but the murmur at the pulmonic area appears to show a more diamond-shaped contour, thus resembling an ejection murmur. This configuration might possibly be due to a superimposed ejection murmur originating from the pulmonic valve region as a result of an abnormally great blood flow through this valve.

A third heart sound is also present in this figure and is commonly found in ventricular septal defect as a result of the torrential blood flow across the mitral valve into the left ventricle. The systolic murmur of ventricular septal defect itself usually is indistinguishable from that associated with mitral or tricuspid insufficiency, both of which encompass the entirety of systole.

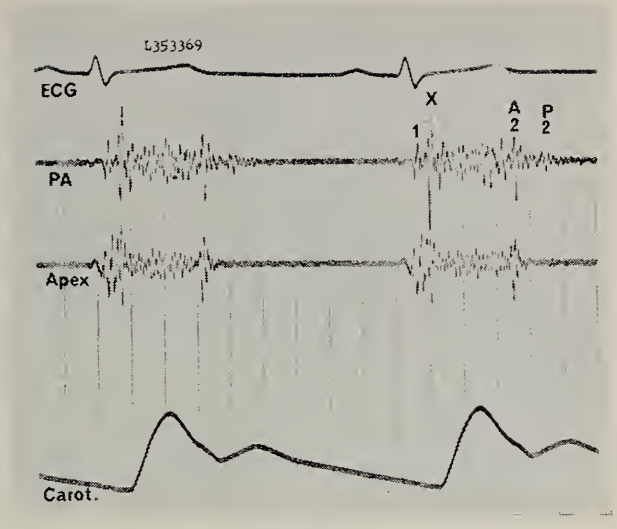



FIGURE 11
**PULMONIC STENOSIS** with ejection click (X), wide splitting of second sound and systolic ejection murmur.

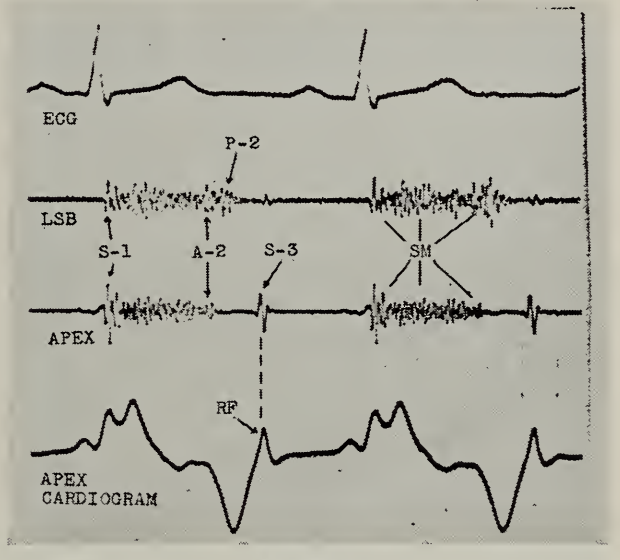



FIGURE 12
**MITRAL VALVULAR INSUFFICIENCY** with pansystolic murmur and third heart sound.




FIGURE 13
**VENTRICULAR SEPTAL DEFECT** with pansystolic murmur and third heart sound.

For this reason, these lesions often are difficult to differentiate clinically. The location of the murmur's maximum intensity on the surface of the chest frequently is helpful, but often one must utilize the associated clinical findings in order to reach an accurate diagnosis.

### Differentiation of Systolic Murmurs

One often encounters difficulty, in a clinical setting, in differentiating between ejection and regurgitant murmurs. The "diamond-shaped" configuration of ejection murmurs may be difficult to appreciate on auscultation and even on the sound recording, particularly when it shows atypical radiation (aortic murmurs often radiate to the apex) or is long in duration. Murmurs due to valvular incompetence also may be atypical, often confined to late systole, or not having a smooth plateau throughout systole. One occasionally finds it necessary to use auxiliary means to help differentiate between these two types of murmurs.

Exercise increases cardiac output and stroke volume and tends to intensify ejection murmurs while leaving regurgitant murmurs relatively unaffected. The administration of amyl nitrite by inhalation increases cardiac output and intensifies ejection murmurs, but it also brings about a drop in systemic arterial and left ventricular pressure, thereby reducing the amount of regurgitant flow (if such is present) and, consequently, reducing the intensity of most regurgitant murmurs. For this reason, we have found amyl nitrite to be especially useful clinically. Systolic murmurs due to mitral insufficiency and ventricular septal defect are reduced by amyl nitrite, but the murmur caused by tricuspid insufficiency is often increased.[6]

Figure 14 shows the marked accentuation of a systolic ejection murmur following administration of amyl nitrite; the murmur was caused by mild aortic stenosis.

If the heart rate is irregular, as in atrial fibrillation or when extra systoles are present, beats following longer pauses have a greater stroke volume. Hence, if an ejection murmur is present, it will be louder at these times. Under such circumstances, regurgitant murmurs do not change. Figure 15 exemplifies this phenomenon in a patient with atrial fibrillation associated with mitral and aortic valve disease, in whom an ejection murmur is present.

### Diastolic Murmurs

The phonocardiogram in Figure 16 was taken from a patient with predominant aortic insufficiency and shows the typical

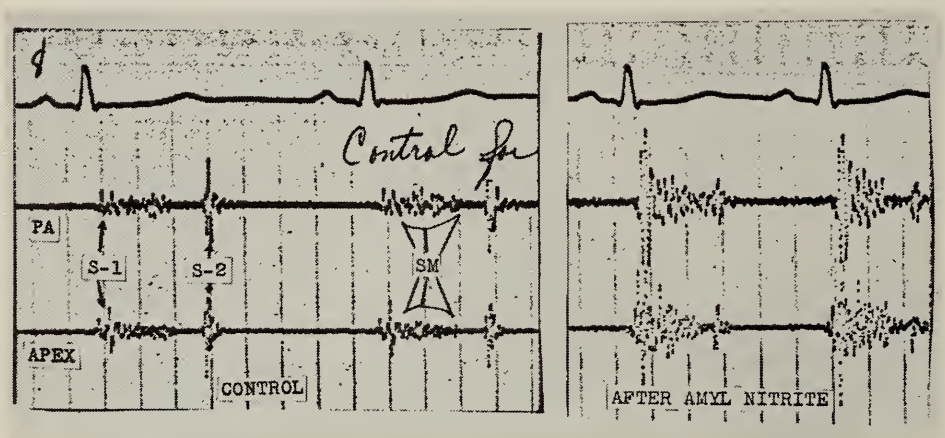



FIGURE 14
MILD AORTIC STENOSIS. Effect of amyl nitrite on systolic ejection murmur.

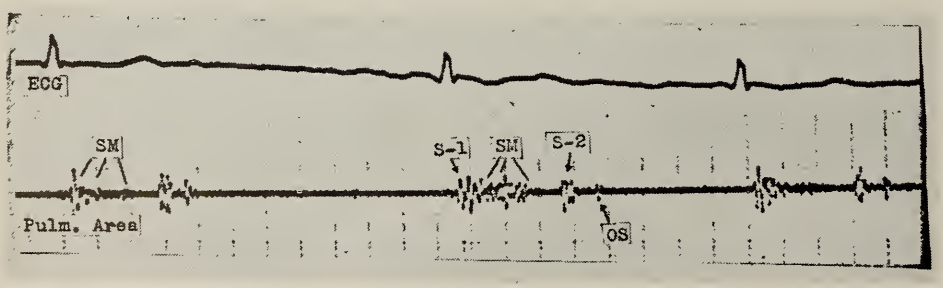



FIGURE 15
AORTIC AND MITRAL VALVE DISEASE. Increased amplitude of ejection murmur (SM) with long preceding diastolic interval.

decrescendo diastolic murmur. Note that the murmur begins immediately after the second sound (aortic closure), a fact which helps to differentiate it from the diastolic murmur of mitral stenosis, as will be seen in the next example.

Figure 17 shows the typical diastolic murmur of mitral stenosis. In contrast to the murmur of aortic insufficiency, this murmur does not begin until after the mitral valve has opened, a point which is indicated by the opening snap. There is thus a silent gap between the second heart sound and the onset of the murmur in mitral stenosis, a point of vital clinical interest. Note also in this example the presystolic accentuation of the murmur, resulting from increased blood flow across the mitral valve during atrial contraction. This accentuation is obviously absent in atrial fibrillation (Figure 7).

### Continuous Extracardiac Murmurs

Figure 18 shows a tracing taken from a patient with a patent ductus arteriosus and exemplifies at the pulmonic area the continuous, systolic-diastolic murmur as seen in extracardiac murmurs where blood is flowing from a high to a low pressure area. This type of murmur is loudest around the time of the second sound, gradually diminishing during diastole. Although the classic example of this murmur occurs in patent ductus arteriosus, such a murmur can also arise from arteriovenous fistulae, communications between the sinus of Valsalva and the right heart, and other conditions.

### Carotid Pulse Contour in Aortic Stenosis

Figure 19 contrasts the normal carotid pulse record with that seen in aortic stenosis. Note the long delay in the ascending limb of the abnormal tracing before it reaches its peak, together with a prominent anacrotic notch (a). The total ejection time is also significantly prolonged, as measured from the beginning of the upsweep to the dicrotic notch, the latter being difficult to visualize in this example. The carotid pulse tracing usually is abnormal in aortic stenosis. Thus, this tracing is useful in clinical medicine to help decide which ejection murmurs are due to aortic stenosis.[7] It is not infallible for this purpose, however, for occasionally the carotid pulse tracing is within normal limits despite the presence of significant aortic stenosis.

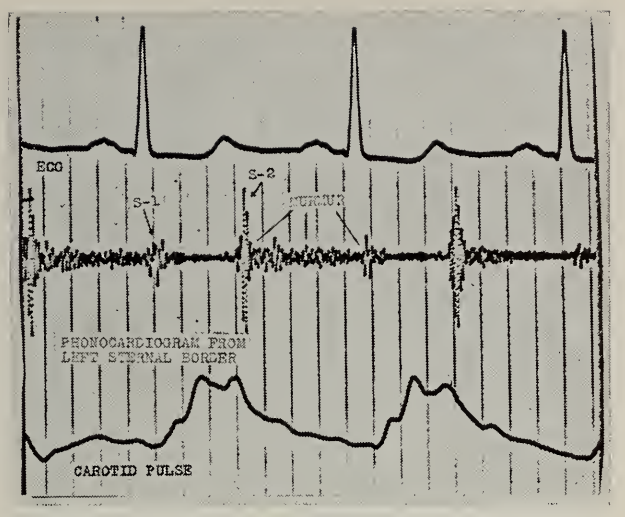



FIGURE 16
AORTIC INSUFFICIENCY with decrescendo diastolic murmur.

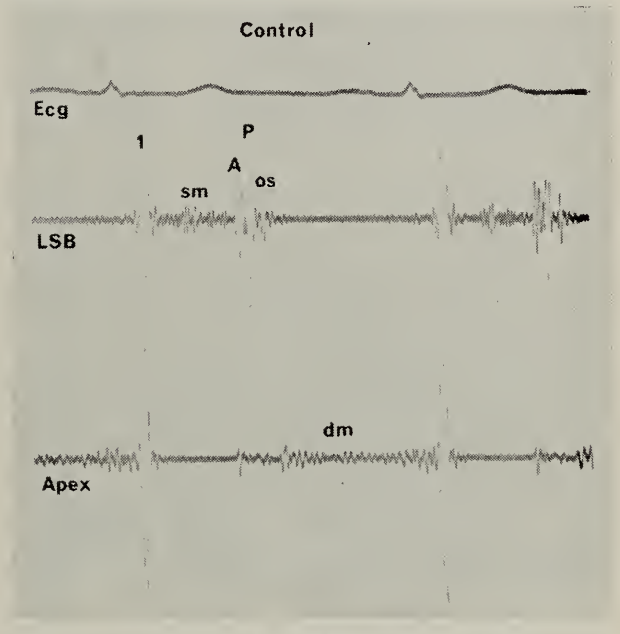



FIGURE 17
MITRAL STENOSIS with diastolic murmur (dm) at the apex. At the lower left sternal border are A2, P2 and the opening snap (os). Note also a soft systolic ejection murmur at the LSB.

### The Jugular Pulse

Figure 20 displays the normal jugular pulse tracing in a healthy young male. The normal heart sounds with their components can be seen in the same record. As recorded by this method, the jugular pulse is a close approximation of the right atrial pulse contour but is unsatisfactory for quantitative pressure determinations. The "A" wave is

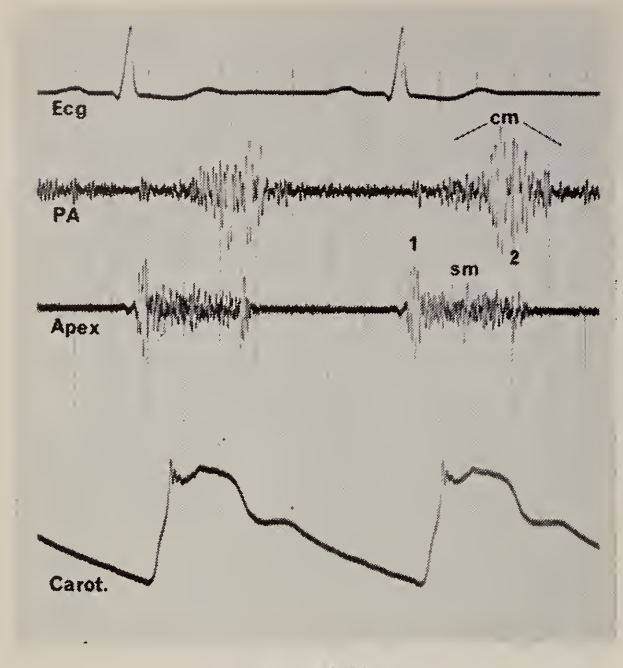



FIGURE 18
PATENT DUCTUS ARTERIOSUS with continuous systolic-diastolic "machinery" murmur (cm) at the pulmonic area. A pansystolic murmur is registered at the apex.

caused by atrial systole and precedes the first heart sound by a short interval. The "C" wave is associated with beginning ventricular contraction. The "V" wave results from atrial filling during ventricular systole, its downslope reflecting opening of the tricuspid valve. The "H" wave probably represents the end of ventricular filling.

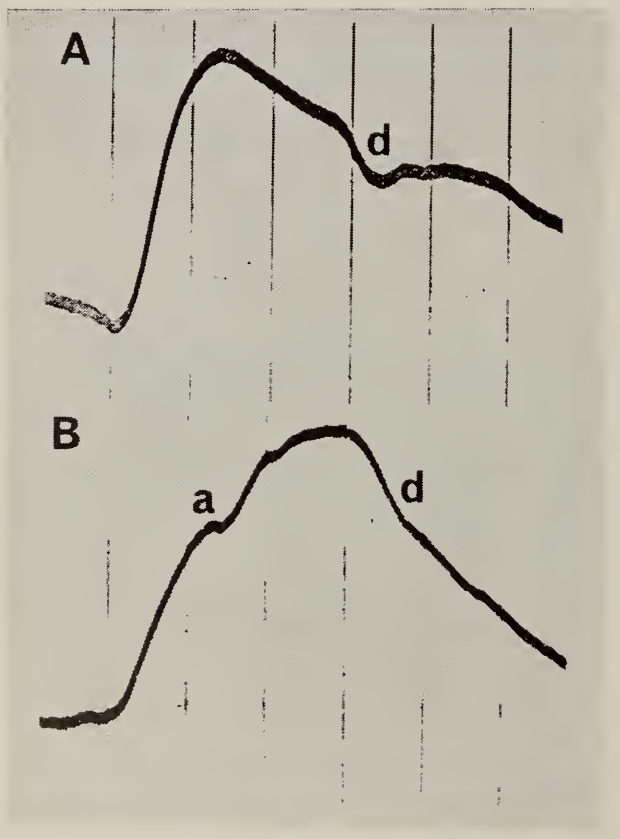



FIGURE 19
CAROTID PULSE TRACINGS, showing contrast between normal (A) and aortic stenosis (B); a=anacrotic notch; d=dicrotic notch.

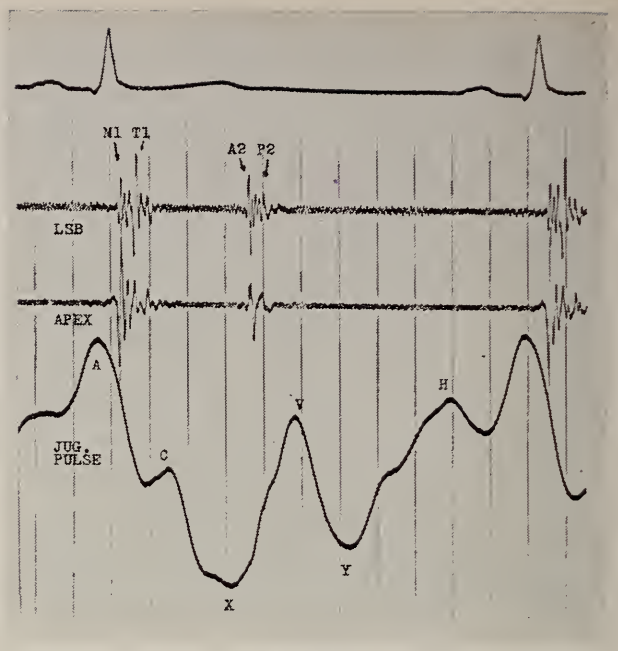



FIGURE 20
NORMAL JUGULAR PULSE together with normal sounds.

Because of limited space, we shall not show jugular pulse abnormalities.

## Summary

Elucidated by a series of illustrations, phonocardiography and external pulse recording are described. These techniques help the physician to improve his auscultation, supplement his bedside findings, and deduce intra-cardiac events more accurately.

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# Absorption of Sodium Chloride from Normal Saline Enemas

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J. O. RITCHEY, M.D.†
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THE USE of normal saline enemas in the preparation of patients for x-ray examinations raises the question of a possibly harmful effect in patients with congestive heart failure or malignant hypertension. Even small amounts of sodium may harm such persons and meticulous care is executed in routine clinical management to avoid the uptake of any excessive amounts of sodium. In the preparation for x-ray examination, however, the patient may be exposed to a large volume of saline, for he may be given as many as three enemas consisting of one liter of saline each.

There are several factors to be considered in estimating the amount of saline which may be absorbed. By radiographic study it is known that a large portion of the surface of the large bowel is exposed to enema solutions.[1] The length of exposure time for absorption is a factor which is quite variable, though a cleansing enema is usually expelled shortly after its introduction. Although it is already known that there is considerable absorption of saline by the large bowel,[2,3,4] we wished to know more —i.e., the exact amount of sodium actually absorbed from saline enemas.

A study of the amount of sodium retained after the administration of sodium phosphate enemas has revealed retention in the bowel of from 90 to 3110 mgs. of sodium. The average amount retained was 810 mgs. (35 mEq.) of sodium.[3] Presumably this amount was ultimately absorbed into the body. The present study differed inasmuch as an attempt was made to determine the absorption of sodium chloride rather than a combination of sodium biphosphate and sodium phosphate. A second major difference was the utilization of radiosodium which was introduced as part of the enema solution and measured directly in the serum.

### Method

To assure clinical applicability, the enema was given as part of a routine gallbladder examination. One liter of normal saline containing 80 microcuries of sodium 22 was introduced in a routine fashion in the morning. Blood samples were obtained at various intervals up to 72 hours.

The total body sodium was determined by radioactive sodium dilution determination 72 hours after the study had begun. Twenty microcuries of sodium 22 were used for this purpose. The patients were asked to collect all of their urine and the radiosodium excretion via this route was calculated. In calculating the total body sodium, a correction was made for the residual radioactivity in the serum. This was done by plotting the rate of decline of serum radioactivity and by projecting this curve through the next two days. These predicted values of the residual radioactivity were subtracted from the observed values.

Two ml. of serum were counted as was a two ml. aliquot of the 24-hour urine collection. A standard Picker well counter was utilized for this purpose.

The major route of sodium excretion is by way of the kidneys. The sodium 22 lost from the body in this manner was measured. The excretion of sodium from other sources, namely via the sweat and feces, amounts to only a small portion of the amount lost from the body by way of the kidneys.[5] The total amount of radioactive sodium absorbed was calculated by the usual formula, utilizing the principle of the

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dilution of a radioactive substance in a semipermeable system, with the precalculation of the total body sodium as a base factor.

## Results

Analysis of the compounded data shows that a significant amount of sodium is absorbed from a normal saline enema. The normal daily intake of salt is about five grams or 85 mEq. of sodium. Up to one-half of this figure was absorbed from the saline enema solutions. This is felt to represent a significant factor in patients with salt intake restrictions.

A wide variability of the amount of sodium absorbed was observed. This probably correlated with several factors, i.e., the length of time the enema solution was retained, the amount of enema solution left in the colon after evacuation of the enema and the presence or absence of congestive heart failure.

Serial counts of the sodium 22 concentration in the serum revealed that absorption through the large bowel mucosa was a rather slow one. The maximum count in the serum was usually encountered some two to 24 hours after administration of the saline enema. The time of the maximum level cannot be pinpointed since an inadequate amount of interim counts were obtained.

The reliability of this method was felt to be reasonably good. Although multiple calculations had to be carried out, all of these calculations were of simple nature and the error margin was relatively low. An adequate amount of counts per minute had been ascertained to avoid a significant statistical variant and error.

## Summary

The use of saline enemas to routinely prepare patients for x-ray examination might be expected to lead to a significant absorption of sodium. To determine the amount of sodium actually absorbed saline enemas were tagged with $^{22}Na$. The concentration of this isotope was measured in the plasma. The quantity of sodium retained in the body varied widely, but in two of nine patients was over 40 mEq. It is suggested that saline enemas be avoided in patients with a precarious cardiovascular status.

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RAW DATA (IN COUNTS PER MINUTE) AND RESULTS

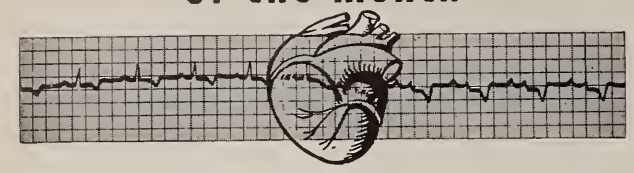
| Time interval | DW mild congestive failure | ME congestive failure & emphysema | KB congestive failure, diuresing | MH mild congestive failure, salt-losing nephritis | WT normal post-op. | MM allergic asthma | GE ulcer with recent severe anemia | RP jaundiced, carcinoma of ampulla of Vater | JM compensated failure, terminal multiple myeloma |
|---|---|---|---|---|---|---|---|---|---|
| 45 min. | 89 | | 39 | 37 | | 34 | | | |
| 1 hour | 138 | | 61 | 66 | 143 | | | | |
| 2 hour | 161 | 251 | 76 | | 155 | | | 118 | 3 |
| 4 hour | 143 | | | | | | 39 | | |
| 6 hour | | | | | | | 39 | | |
| 8 hour | | | | | | | 41 | | |
| 24 hour | 140 | 304 | 65 | 89 | 137 | 48 | 45 | 106 | 6 |
| 48 hour | 132 | 177? | 66 | 84 | 140 | 42 | 34 | 100 | 7 |
| 72 hour | 134 | 247 | 61 | 74 | | 37 | 30 | 98 | |
| AMOUNT OF SODIUM ABSORBED (mEq.) | | | | | | | | | |
| 24 hour | | 49 | 19 | 16 | 42 | 10 | 12 | 27 | 2 |
| 48 hour | 30 | 52 | 20 | 16 | 42 | 8 | 13 | | 2 |

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## From *The Journal* 50 Years Ago

. . . It has been my privilege and pleasure to have had some little experience in the use of nitrous oxid in obstetrical anesthesia. So far my impressions have been favorable. I have seen nothing unfavorable that could be in any way associated with the use of the gas; on the other hand, there have been a few things that are very definitely in its favor. In the first place, the relief from pain is certainly marvelous. You are all familiar with the hours of intense pain that go dragging along during the stage of dilatation, when, under the old regimen, we were taught it was unsafe to give ether or chloroform, because we did not know but what that might be kept up from five to ten hours. But under the gas anesthesia it has been my observation that it is safe to begin the gas when the woman began to make any bitter complaint of pain, even apparently early in the dilating stage. And my experience has been that it acts as an accelerant to labor without any disastrous results. Whether it does this by minimizing the inhibitory action of fear, I am not sure, but certainly the results are most satisfactory . . . . Dr. W. D. Hoskins discussing Dr. Arthur E. Guedel's paper "Nitrous Oxid Anesthesia in Obstetrics" *JISMA*, March, 1915.

# Electrocardiogram of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Effect of Potassium on Ventricular Premature Beats*

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THE THERAPEUTIC as well as toxic effects of potassium on the formation (automaticity) and conduction of the impulse have been repeatedly stressed. In addition to replacing the body's stores of K, the cation is an excellent antiarrhythmia drug. One serious drawback to the use of K is its transient effect and the need for giving the drug at three to four hour intervals until the effects of the agent which instigated the disturbance in rhythm is dissipated. On the other hand, K depresses A-V as well as intraventricular conduction and thus should be used with caution in the presence of conduction defects, particularly in those patients intoxicated with digitalis. One of the major reasons why K is a useful therapeutic agent is probably due to the fact that the cation depresses ectopic automatic foci at plasma K levels lower than those necessary to depress conductivity.

Figure 1 exemplifies (1) the antiarrhythmic properties of K, (2) its shortlived effect and (3) the dissociation of the action on automaticity (ectopic focus) and A-V conduction.

The control tracing (8:30 a.m.) demonstrates a P-R of .26-.28 seconds and ventricular premature systoles (VPS) at a plasma K level of 4.2 mEq/L. Two hours following administration of 80 mEq of K (11:00 a.m.) and the K level raised to 6.2 mEq/L, the VPS are no longer evident, only to reappear two hours later (1:00 p.m.) with the decline of the plasma K level. At a time when the arrhythmia was abolished, K had no demonstrable effect on the A-V conduction.

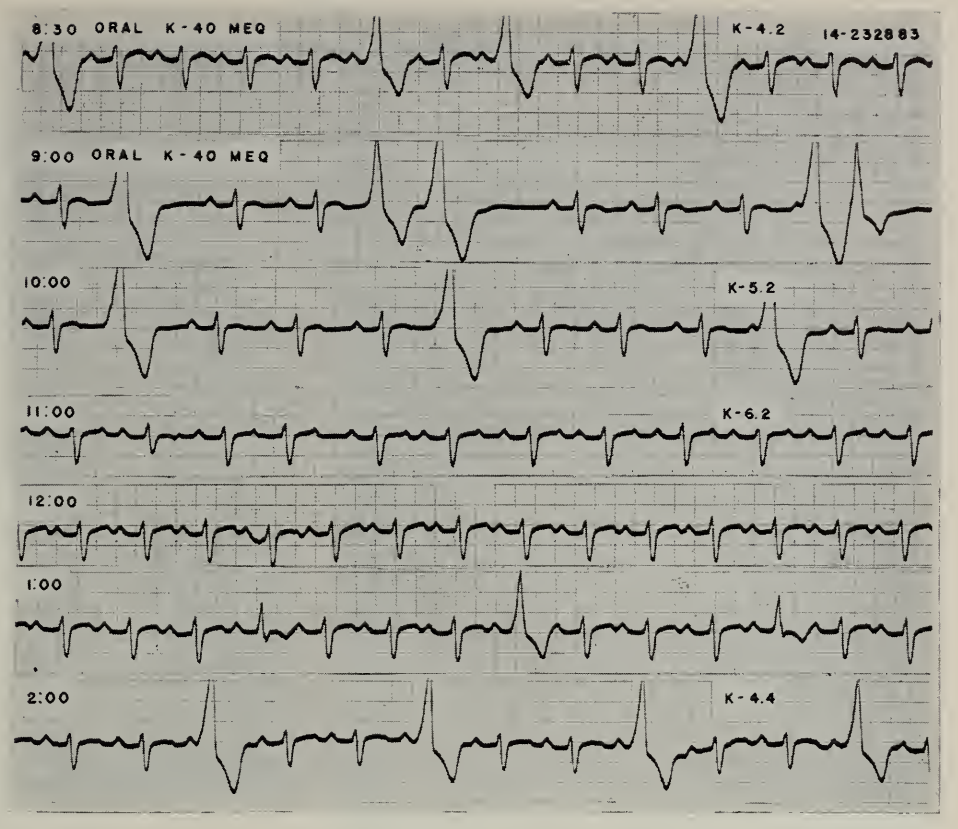



**FIGURE 1**
**THIS FIGURE** demonstrates the effect of K on ventricular premature systoles. For details see text.

## NEXT MONTH IN *THE JOURNAL*

**Dr. John H. Ivy, of Elkhart, will discuss the prevention and management of hospital infections, based upon a six-year experience of a well-functioning medical staff committee.**

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Bronchography as a "Follow-Up" Examination For Patients With Bronchogenic Carcinoma

ERICH K. LANG, M.D.*
*Indianapolis*

A 46-YEAR-OLD white male first sought medical care for recurrent "chest colds" on the right side. Serial chest roentgenograms, over a period of nine months, revealed recurrent pneumonic infiltrates in the right middle lobe. The hilum was inconspicuous on the earlier films. However, during the last admission, the plain roentgenogram showed unequivocal findings of progressive hilar enlargement (Figure 1). This called for a bronchogram. A significant deviation and extrinsic compression of the medio-caudal segment of the right lower lobe around a mass lesion was readily observed. There appeared to be direct invasion and nearly complete obliteration of the main segment of the right middle lobe bronchus.

Only minimal filling of the medial subsegment could be achieved (Figure 2). Bronchoscopic examination revealed the carina to be in midline and showed no significant thickening or fixation. The right main stem bronchus was of normal caliber to just below the level of the right upper lobe orifice. At that point, a marked annular constriction involving the middle lobe orifice was noted. The lower lobe presented as a slit-like opening. The tissue appeared to be grossly neoplastic. A biopsy specimen revealed an undifferentiated bronchogenic carcinoma.

The patient was subsequently subjected to a course of cobalt therapy, delivering a tumor dose of 4,500 rep to the tumor-bearing area via opposing AP and PA ports. The follow-up films revealed prompt regression of the mass in the lower right hilum and clearing of the pneumonic infiltrate in the right middle lobe. It was felt that with shrinkage of the tumor mass, continuity of

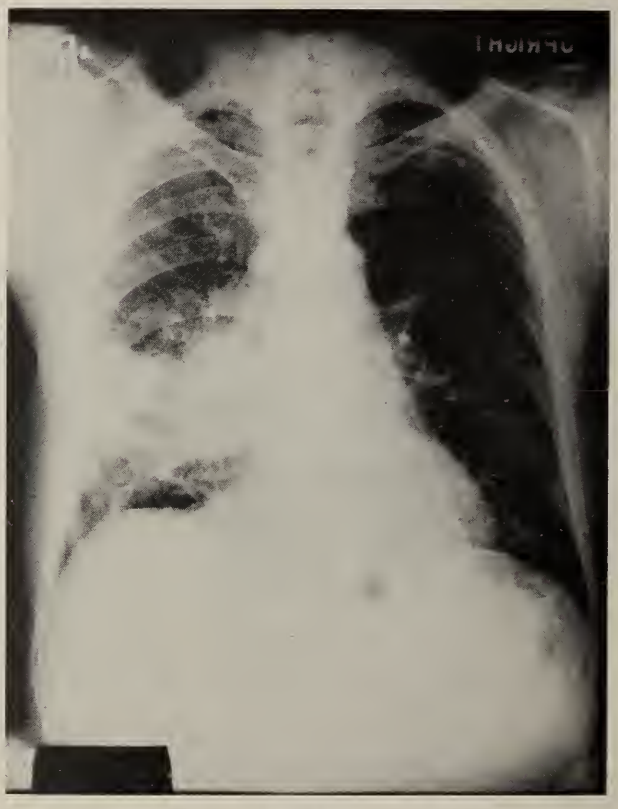


**FIGURE 1**

**PARTIAL atelectasis and pneumonic infiltration of particularly the lateral segment, but also to a lesser extent, the medial segment of the right middle lobe. Note a large mass in the lower part of the right hilum.**

* Department of Radiology, Methodist Hospital, Indianapolis.

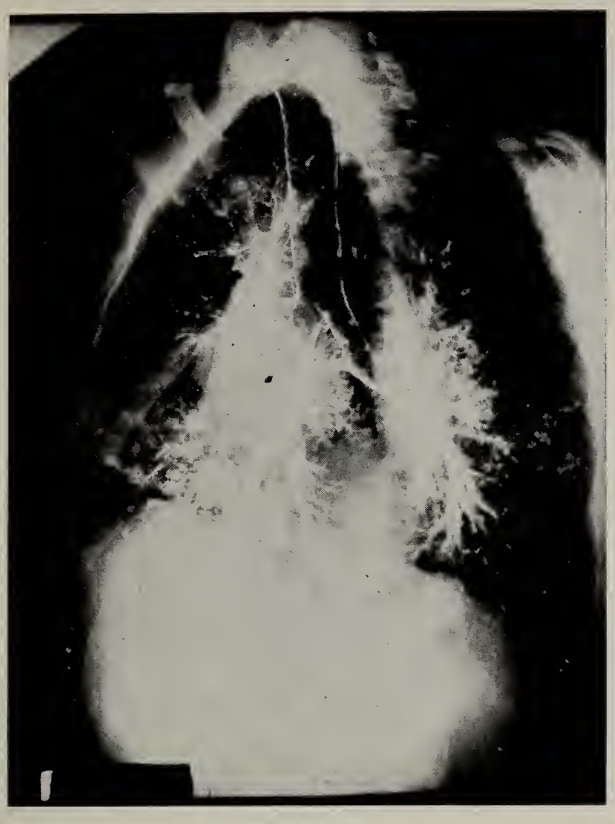


FIGURE 2

NOTE the marked compression of the right main stem bronchus immediately below the orifice of the right upper lobe bronchus. Only a minimal amount of contrast medium enters the right middle lobe and distributes in the medial segment of the right middle lobe bronchus. Direct invasion of the right middle lobe bronchus is seen.

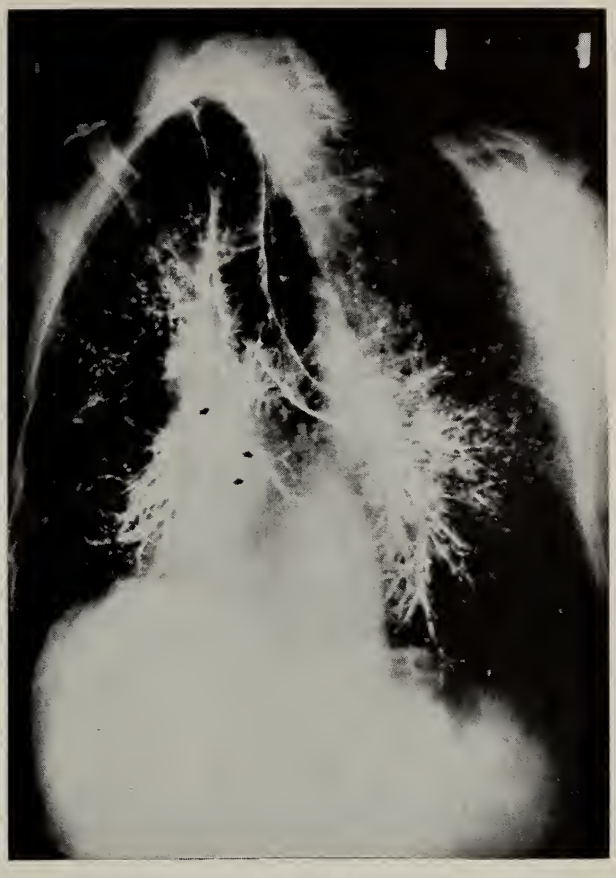


FIGURE 3

THE right middle lobe bronchus is now normal in appearance (seven month post-Cobalt 60 therapy). There is a nearly complete block of the right lower lobe bronchus. Direct tumor invasion in the superior segment and the medio-caudal segment is demonstrated. The posterior segment is abruptly cut off. The anterior segment is displaced towards anterior by a tumor mass.

the bronchial tree was re-established and adequate drainage and aeration of all segments guaranteed.

Some seven months later, the patient returned with symptoms of recurrent pneumonitis. A chest roentgenogram at that time revealed atelectasis and pneumonia of the right lower lobe. A bronchogram was again performed. It is of interest to note that the middle lobe had almost completely normalized and was well re-expanded and the bronchus appeared to be widely patent. However, the posterior, anterior and lateral segments of the right lower lobe were completely amputated and atelectasis and pneumonitis had resulted in the distal lung components supplied by these bronchi. Direct tumor infiltration into the medio-caudal segmental bronchus of the right lower lobe was apparent. The irregular splayed cut-off of the posterior segmental bronchus of the right lower lobe showed direct tumor invasion (Figure 3).

## Technic

Bronchograms are carried out under local anesthesia. A nebulizer is utilized to obtain maximum anesthesia of the oro-pharynx, the upper trachea and the main bronchi. A two percent xylocaine spray is favored. A slanted side-hole curved bronchial catheter is utilized for selective engagement of all main bronchi. Hydrast is favored as the contrast medium since it will allow excellent staining of the main and segmental bronchi, even in the presence of residual mucous. By monitoring the selective injection of the main bronchi, prone, PA and two posterior oblique, as well as upright, PA and two posterior oblique films are obtained. After completion of the procedure, re-aspiration of some of the contrast medium is attempted. This minimizes the febrile response to hydrast, particularly in areas of obstruction or poor drainage.

The bronchogram not only allows excellent demonstration of endobronchial disease but also of extrinsic compression of the

main bronchi. Moreover, the area of the carina is readily assessed and the presence or absence of node masses is reflected by the characteristic splaying of the main stem bronchi. In inoperable cases, this offers excellent localization of the tumor mass and allows proper arrangement of therapy ports to cover the entire area involved. It also offers the opportunity of determination of operability.

**Summary**

Bronchography provides a useful tool for primary diagnosis of endobronchial disease or compression of bronchi and particularly for the follow-up of tumors treated by radiation therapy.

Apart from febrile reactions, usually caused by trapping of contrast medium in partially obstructed areas, no untoward effects have been recorded. ◄

## About Our Cover

The Physician's Art and Hobby Show is always one of the favorite attractions at the ISMA Annual Convention.

But there would be no show were it not for the untiring efforts of Dr. Philip T. Holland, Bloomington, and his committee. Some of the many problems incurred each year by Dr. Holland and his co-workers are discussed in his special article on p. 248 of this issue of *The Journal*.

This month's cover is made up of pictures taken at some of the Art and Hobby Shows of past years: (top left) Dr. V. Earle Wiseman, Greencastle, discusses one of the exhibits with Dr. Sam Rotman, Jasonville, at the 1964 annual convention; (top right) Dr. Lall G. Montgomery, Muncie, shows Dr. Holland a music rack he made out of various types of fruitwood from the family orchard; (middle left) photography is one of the many varied categories which are offered each year; (middle right) painting is another; (lower left) visitors at the 1962 convention in French Lick discuss the merits of various paintings; (lower right) Dr. Ray H. Burnikel, Evansville, shows Dr. Eugene F. Senseny, Fort Wayne, his orchid collection.—J.F.S.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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# Dr. Glenn W. Irwin, Jr. Named I.U. Dean

DR. GLENN W. IRWIN, JR., professor of medicine, has been named dean of Indiana University School of Medicine. He assumed the duties on March first.



Dr. Irwin, who is well known to many of the physicians of Indiana, is a graduate of I.U., having won his M.D. degree in 1944. He was an intern at Methodist Hospital in Indianapolis, and then completed a divided residency in medicine at the I.U. Medical Center, with a tour of duty with the Army Medical Corps as the divider.

He has been a member of the faculty of his alma mater since 1950 and has distinguished himself in the medical specialty fields of metabolism and endocrinology. Dr. Irwin is also well known as an outstanding teacher and in this capacity has been the mentor of physicians graduated during the past 15 years as well as many others who have become acquainted with him during postgraduate courses.

The university has made a wise choice. Dr. Irwin will make a splendid dean. Comments from the medical profession of the state indicate concurrence.

The sentiments of Indiana physicians can be adequately portrayed by quoting President Elvis J. Stahr: "The search for candidates who could meet the standards ranged nation-wide. It is most gratifying to me to find that this eminently qualified man is right on the campus, and I'm equally gratified that he has agreed to take the assignment as we move into these critical years of further building and developing the full-time faculty, the physical facilities and the services to the physicians and people of Indiana which a first-rate school of medicine provides."

*The Journal* offers congratulations to the university and to Dr. Irwin and wishes a long and fruitful association for both.

# Tribute to John I. Nurnberger, M. D.

THE APPOINTMENT of Dr. Glenn Irwin, Jr., as dean of Indiana University School of Medicine prompts an acknowledgment of the services of Dr. John Nurnberger who has served as acting dean since the death of Dr. John Van Nuys.

Dr. Nurnberger's contribution to the integrity and smooth functioning of the school is more to be appreciated since he has continued his duties as Head of the Department of Psychiatry and Director of the Institute of Psychiatric Research, two important posts to which he will now be able to devote his full attention.

Dr. Nurnberger was especially cited in the announcement of Dr. Irwin's appointment and was commended by President Stahr for a superb job.

*Guest Editorials*

# *A Call To Arms*

THE INCREASING FREQUENCY of vicious and flagrant attacks against Organized Medicine by certain connotations and editorial writers is arousing even the most peaceful of our colleagues to righteous anger. For example, a recent Scripps-Howard cartoon depicted a physician strangling an elderly patient (Medicare) in a wheelchair with a blood pressure cuff around his neck while assuring him that everything possible was being done to help him. This libelous attack was answered in a letter to the editor of the *Post-Times Star* and we have requested the AMA to take action, if possible, on a nationwide basis. Another example occurred when a newscaster maliciously attacked the Academy of Medicine of Cincinnati for opposing the seeking of federal funds to erase "smallpox, diphtheria, and polio" (omitting to mention, of course, that we have no smallpox, diphtheria, or polio in Cincinnati). Actually, there was no communication whatsoever between the Health Department and the Academy of Medicine either to approve or disapprove the seeking of federal funds. The commentator insinuated that physicians of Cincinnati were concerned only with their fees, and that they opposed immunization of patients against polio two years ago. The truth is, however, that the Academy of Medicine and physicians of this community put on a mass polio vaccination drive within eight days of the discovery of one case of Type III poliomyelitis in Cincinnati. In addition to this there was a citywide program for immunization with Salk vaccine and with the other type types of Sabin vaccine.

The question arises, just what should we do about this obvious campaign of vilification? Suffer in silence as a noble profession, and not to stoop to answer such charges? The Council of the Academy of Medicine believes that the time for passive acceptance of any sort has gone by, and that we must respond vigorously. It strains one's credulity to view the charges raised against us as mere errors in judgment. Obviously, such statements are part of an organized campaign to discredit us in the minds of our people, to debase the private practice of medicine, hoping in turn for Government Medicine.

Selection of the best method of defense is not easy. Counterattack, using the same technique used against us by these irresponsible people, would reduce us to their level. The dignity of the medical profession must be maintained. Attempts to answer every attack against us is practically an impossibility for any physician in active practice. Furthermore, widespread news coverage of an answer to a false charge gives those who defame us far more publicity than they would ordinarily obtain. Selected, cool, logical but forceful replies are in order and will be given to the best of our ability. In this campaign we must put aside petty differences and stand together, lest our attackers defeat us by the "divide and conquer" technique.

If any member of the Academy of Medi-

cine has suggestions as to how we can present our story more effectively, your Council will appreciate hearing from you.—John J. Cranley, M.D. Reprinted from the *Cincinnati Journal of Medicine* 46:1, p. 7, 1965.

## Phenylketonuria

PHENYLKETONURIA is an inborn error of metabolism which prevents an infant from properly utilizing phenylalanine. If PKU is not detected and is not treated early in life, brain damage manifested as mental retardation will be the likely result. This disorder can be detected by the third or fourth day of life using blood screening methods. Methods of detection using urine may not become positive under two to six weeks of age. Testing for PKU should be done on every infant as a part of preventive health care.

Indiana has 54 screening programs. Eleven of these are blood screening programs in which the infant is tested just before discharge from the hospital, usually three-four days of age. The rest are urine screening programs using ferric chloride or Phenistix* methods. These infants are tested between two-six weeks of age. Regardless of what screening test is used, a *quantitative blood phenylalanine level* is necessary to confirm the diagnosis of PKU. Quantitative blood phenylalanine levels, also, are necessary to follow the progress of the child after treatment is instituted.

There have been 129 cases of phenylketonuria reported to the Indiana State Board of Health. Fifteen of these cases were reported in 1964.

The treatment for this disease is primarily with a diet low in phenylalanine. Consultation service is available from the Division of Nutrition, Indiana State Board of Health, when requested by the local health department.—Verne K. Harvey, Jr., M.D., Director, Bureau of Special Health Services, Indiana State Board of Health.

* Registered trademark of Ames Company, Inc., Elkhart.

## Editorial Notes...

**The Advisory Council on Social Security is quoted as saying: "It (Social Security) is an institution through which all Americans together promote economic security by financing, from the contributions of all, a continuing income to families whose earnings are cut off by old age, death or disablement of the worker."** In Russia this is called Communism. Remember? "From each according to his talent, to each according to his need."

---

**The nomenclature for sports injuries which has developed haphazardly over the years will be subjected to standardization by the AMA Committee on the Medical Aspects of Sports.** Most of the colorful terms are considered useful but require definition and precision to make them adequate for statistical purposes. It is heartening to learn that locker room terms such as "charley horse," "hip pointer" and "shin splints" will not be lost to the language but will end up as synonyms for medically precise conditions.

---

**Polio is on its way out!** There were only 121 reported cases last year; the lowest incidence of all time. Contrast this with 42,033 cases in 1949, 57,879 cases in 1952 and 38,476 cases in 1954.

---

**The Aedes aegypti mosquito, the vector of yellow fever, infests most of the Southern states, Puerto Rico and the Virgin Islands.** There is no incidence of yellow fever, however, because the mosquitoes are not infected with the virus. Public Health officials are anxious to eradicate the Aedes aegypti since the virus could be accidentally introduced from Latin America with resulting epidemics of yellow fever. A program of eradication is being planned by the AMA and the PHS. ◄

# President's Page

The specially called meeting of the House of Delegates of the AMA was held in Chicago February 6-7 and was attended by ISMA officers, delegates, alternate delegates and other interested physicians.



Your Indiana delegation proposed Resolution #3 which was tabled but the actual intent of the resolution was covered by a California resolution which embodied the idea of liberalized Kerr-Mills and creating an easier acceptance for assistance. The AMA did not actually wish to discuss participation of all needy persons, regardless of age, so that was the considered reason for the tabling of our resolution.

President Donovan Ward gave an excellent presentation of the stand of the AMA. Excerpts from his speech follow:

"Are 200,000 doctors wrong in urging the Congress to give serious consideration to the one measure now before it that offers genuine medical and hospital benefits to the needy aged? This is a bill authored neither by the Republican party nor the Democratic party. It is a bill with bipartisan parentage—the Herlong-Curtis Eldercare bill, numbered H.R. 3727. We urge Congress to compare, and the people to compare, this bill with its genuine benefits and realistic financing—and with its provision allowing for administering a health program through health agencies of the states—to compare it feature-by-feature with Medicare.

"If the drums can be stilled long enough to make this comparison, it will be found that the Herlong-Curtis Eldercare bill can cover not only the cost of hospital care and nursing homes for the aged, but also payment of physicians and surgical and drug costs—which Medicare would not do."

Dr. Ward declared that "it is never too late to pass good legislation and defeat bad legislation. The one thing in this historic decision—the only thing—that may truly come too late, is regret."

My personal plaudits go to the active, energetic efforts of the Commission on Legislation which has met every week since the onset of the present General Assembly. They have exerted every effort toward the interests of medicine during this session.

Jon Black M.D.



The Doctor's Visit, Jan Steen 1626-1679, Mauritshuis, The Hague

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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

*Research in the Service of Medicine*

# The Woman's Auxiliary

## REPORTS TO ISMA

In my travels over the state this year, I was particularly impressed with the industry of the Randolph County Auxiliary. This group has 15 active members and nine meetings a year. Each November they invite six guests to their "Anniversary Luncheon"—the state president, president-elect, their area vice-president and their three founders, all past state presidents. They actively participate in AMA-ERF, Health Careers, Medical Care Insurance, International Health Activities and do outstanding work in Legislation and in Mental Health. The November election reflected their legislative programs and their tireless efforts in getting out the vote. Their April program will be on "Medicine and Religion" with a minister as speaker and the county minister's wives as guests.

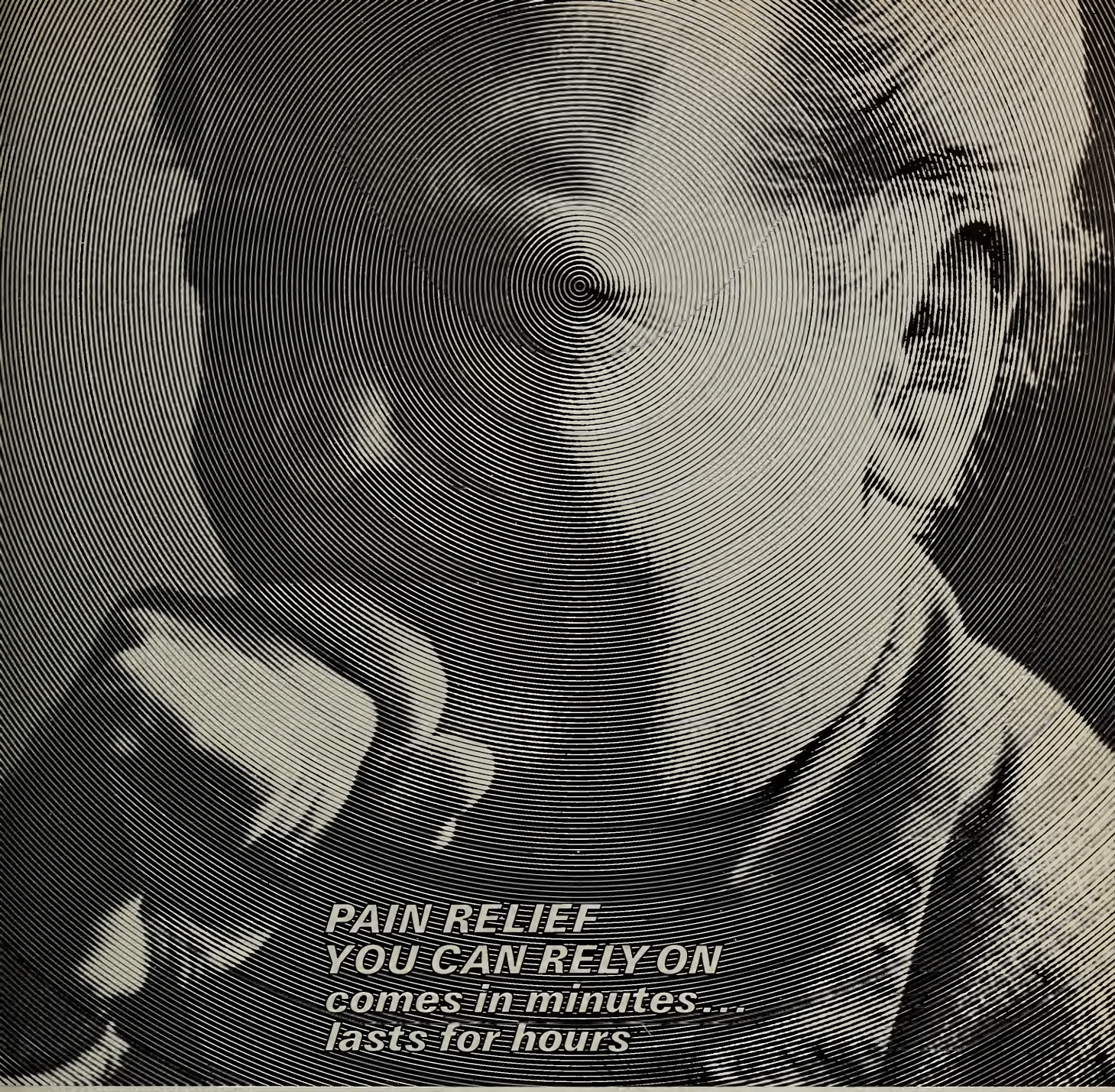


The Randolph County Auxiliary members work together and as individuals in the field of mental health. Their county president, Mrs. L. B. Chambers, has served as a "Gold Lady" at the Richmond State Hospital since 1953, is a member of the state Mental Health Board of Directors and recently has been appointed to a regional committee of the Indiana Mental Health Planning Commission. The Randolph County Mental Health Association has utilized the services of several auxiliary members — Mrs. Paul Sparks has served on the board of directors and as president for two years. Mrs. L. B. Chambers has been a member of the board since it was organized and was president for six years and Mrs. Richard Potter, Mrs. Lowell Painter, Mrs. Russell Engle and Mrs. C. R. Chambers have also served as members of the board of directors.

Mrs. Painter has been a state reporter for *The Hoosier Doctor's Wife* and Mrs. Sparks is completing her second year as state Medical Care Insurance chairman.

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# The Physician's Art and Hobby Show

PHILIP T. HOLLAND, M.D.
Bloomington

THE Indiana State Medical Association Art and Hobby Show has, in recent years, become an established institution and is enjoyed by the doctors and visitors to the annual meeting. Some years ago it was the feeling of the state association that hobbies and crafts are good mental therapy for doctors as a change from the pressures of caring for patients.

It was also felt that if a showing of the many, varied activities that doctors engage in could be made, it would help the public to realize that doctors are not necessarily limited to "wielding knives" and "peddling pills." With these thoughts in mind, and after two or three unsuccessful earlier attempts, the Indiana State Medical Association Art and Hobby Show finally, but definitely, got under way.

It has served as a topic of conversation for those who attend the state meeting each year. It has also been stimulating to the individual exhibitors to observe the work of other exhibitors and to realize that many people are interested in seeing what they have done. There has been favorable comment on our show in both the public press and in the reports of the American Physician's Art Association. It was felt that many physicians might be interested in some of the problems associated with the production of these exhibits. This article will comment on a few of them.

There is difficulty in persuading the doctors to prepare their exhibits and show them. In many cases this is because they are unduly humble about the quality of their product. A lot of extra planning goes into preparing an exhibit. It entails a large amount of physical effort and exertion to ship, carry, or otherwise transport an exhibit and arrange it for viewing. In other cases, it is merely that procrastination is a human trait, whereas other physicians are genuinely so busy that it is difficult for them to find the time to arrange or send an exhibit.

We are exceedingly fortunate in Indiana in having the fullhearted and understanding cooperation of our state medical association. This is not true in some other states. Even with their sincere willingness and desire to cooperate, there are the problems of knowing in advance approximately how much space will be required as, for instance, how much hanging space, tabletop space and space in display cases which can be locked will be needed. Also, there are problems concerning the lighting, the arranging and hanging of exhibits and safeguarding them against the hazards of an exhibition.

Exhibitors, almost without exception, have offered numerous helpful suggestions on all of the basic points. Many find or make the time, and enjoy coming in to assist with setting up the displays so they can be satisfactorily seen. We have made steady, progressive improvement in all these fields each year.

### Classification

The problems of the exhibits themselves pose various questions, the largest of which is classification. Our showings have encompassed such widely varied items as collections of stamps, coins, buttons, spinning wheels, antique cars and gems as well as wood-carving, ceramics, orchid culture, sketching, water-colors, ink drawings, Eskimo drawings and carvings, model railroad trains, knitting, embroidery, collections of books on special topics, steamboat models, items of furniture, oil paintings, black and white photography, modeling-clay figures and pictures telling the story of special hobbies such as floriculture, farm management, etc. The list is a fascinating one and not all have been mentioned here, but this is a representative composite.

Another problem is that of eligibility. We

have limited our exhibition to the work of M.D.'s within the state of Indiana. We have also allowed exhibits by interns, residents and doctors in the Armed Forces currently serving in Indiana.

Our 1964 show was characterized by good value, good quantity and a wide variety of types of exhibits which caused much favorable comment. Some of our shows have been *very* extensive whereas others have been quite limited in amount, but all have had good quality and wide variety.

### Need for New Blood

This leads us to one of the biggest problems, which is that of securing new exhibitors and exhibits each year. It is rather obvious the show would have little value if we were to allow the same exhibits to be entered year after year. This process appears, at least up to now, to be a matter of utilizing the facilities of the Indiana State Medical Association to as full an extent as possible. Individual contacts, letterwriting, phone calls, publicity in *The Journal* and the newsletter of the association are all invaluable aids.

We have the names of all former participants; these we contact each year to see if they have new exhibits or different fields in which they can show. We ask and secure their cooperation in finding other possible exhibitors whom they know personally or of whom they've heard. Then, by personal letter we find out what the possibility is for each one exhibiting. Sometimes, even if they cannot or do not exhibit, those contacted will suggest other possible exhibitors. The members of the committee have been quite active in this regard in their respective portions of the state. This year we had entry blanks and a box for deposit at the show so those who were interested could volunteer an exhibit for next year or list the name of some friend or acquaintance who should be contacted as a possible exhibitor.

### The People's Choice

The problem of the awards has been mentioned briefly before, and naturally, depends partly upon the classifications that will be showing that particular year. We feel, for instance, that painters do not necessarily serve as the best judges of photographic exhibits, or vice versa. Particular hobbies and collections, if there is keen competition in the field, should be judged by individuals who know that particular field.

We have resorted to a rather simplified form of judging for the awards at the last few shows—that of listing exhibits by classes and providing ballots which would allow viewers to pick the winners. This, although not a method of judging by experts, secures a certain degree of "averaging out," in that the individual viewer's technical knowledge and discretion is matched with popular appeal and general artistic merit.

In summarizing the Indiana State Medical Association Art and Hobby Show operation for the past years, it should be said that it has entailed much work throughout the entire year preceding the show, both by the exhibitors and by those in charge. It has been work but it has also been *FUN* as I know exhibitors, the chairman, committee members and members of the state association staff have found. We feel that it has given pleasure to great numbers of viewers and we like to think has encouraged other doctors to take up diverse, interesting and profitable activities for their own benefit as well as the enjoyment of others. ◄

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# Rehabilitation of the Aging*

FRANK H. KRUSEN, M.D.†
*Philadelphia, Pa.*

THE THEME of this year's workshop, "The Four Generational Family in Modern America," is one with which I have great personal sympathy. In Dean Burkhardt's communication to me he mentioned that your group had been impressed with the fact that "there appear to be more and more individuals who, retiring at the age of 65, find themselves supporting parents who are 80 to 85 years of age, and, at the same time, these 65-year-old people have 40-year old children and teen-age grandchildren." Dean Burkhardt concluded, "It seems to us that this phenomenon has some special implication for us all."

I find myself in such a situation. Last June I reached the so-called "retirement age" of 65, and I find myself now in a home where I have living with me a 93-year-old mother-in-law and a 30-year-old daughter, and, when I left my home yesterday, we were entertaining two grandchildren, my 37-year-old daughter's children.

Often now we will find in families two generations, both great-grandparents and grandparents, who may require medical rehabilitation in order to keep them physically, mentally, socially and vocationally as self-sufficient as possible.

Medical rehabilitation can never be separated from the total scheme of the disabled patient's life. This is true of any disabled patient, but especially so in the case of the elderly victim of chronic illness or physical disability. The purely physical aspect of a patient's disability cannot be dealt with in isolation from the rest of his life. For the younger patient, the onset of disability *creates* the corollary problems of physical and economic dependency, housing and recreation. However, in the case of the elderly patient those problems are often already present, even in the absence of an incapacitating or catastrophic disability.

### Familial Adjustment

Typically, the problems of where and with whom to live, how to support and care for one's self, how to spend one's leisure time are the inevitable consequences of reaching advanced age in our society. Severe chronic illness or disability merely intensifies these problems. The very process of medical rehabilitation is the process of adjusting the patient, his family and his environment to a disability. This is quite different from the process of managing a patient with a single, self-limiting condition which will allow him to return to his normal environment.

Hence, medical rehabilitation must deal with the patient within the framework of his total personal, social and physical environment. In the case of the elderly patient, this environment is less easy to manipulate and less capable of adjustment than in the case of the younger patient. The younger patient is usually in the mainstream of life, with a family and perhaps an employer eager to welcome him back and actively helping him to make his way back.

Unfortunately, this is not always the case when we are dealing with the elderly patient.

In medical rehabilitation of the aging, the physician is called upon to fulfill a traditional, but frequently neglected, responsibility—that of providing personal counsel and even moral leadership to the families he serves. I say this because the successful rehabilitation of the aging calls for the acceptance of certain cultural attitudes or moral responsibilities by the family and by society.

One of these attitudes is that the elderly person, if at all possible should be allowed to remain in the home where he raised his

* Presented at the 10th Kirkpatrick Memorial Workshop on Aging, Ball State Teachers College, Muncie, Indiana, February 26, 1964.

† Professor and coordinator, Department of Physical Medicine and Rehabilitation, Temple University School of Medicine, Philadelphia.

children or in the home of the children he raised, or in an environment as much as possible like the one in which his earlier years were passed. Should rehabilitation seek to restore him to these surroundings?

### Are They Worth the Effort?

Secondly, medical rehabilitation calls for a fervent belief in the intrinsic worth of the human being, regardless of his physical abilities and regardless of his potential usefulness. Rehabilitation calls for enormous expenditures of money and time, infinite patience and time-consuming effort. Is the disabled elderly person worth the investment? These are the questions that must ultimately be answered by individual families, by our government and by the medical profession.

To be sure, our society *professes* a belief in the value of the aged person. But our belief has never been tested to the degree to which it *will be* in the coming years when the aged dependent will no longer be a rarity but a reality in millions of families.

The future course of medical rehabilitation will be determined by how our society meets this test.

We must remember that in medical rehabilitation we are not dealing with the old person wreathed with silver hair and benignity whom we find idealized in sentimental paintings and poetry. We are dealing with old people who may be cantankerous, mentally unstable, incontinent and unable to bath, feed or dress themselves.

Medical rehabilitation confronts society with the stark and inescapable necessity of demonstrating how it really feels about old people. For example, at the American Congress of Physical Medicine and Rehabilitation last year, Dr. Victor Cummings of Montefiore Hospital, New York City, presented a report on the elderly disabled amputee. He described the expensive, time-consuming and difficult process of prosthetic fitting and training of such patients. In his discussion, he made this very significant observation on the practical feasibility of such a procedure when, after all of this expense of time and money, the elderly amputee might actually remain ambulant for only a brief period of time, I quote:

"Financial considerations might be raised, but how can we put a monetary value on even six months of comfort, dignity and self-sufficiency in an aged individual who has spent many months in a hospital relying on others for his every need."

Dr. Cummings concluded that, based on his studies, the elderly unilateral below-knee amputees, unilateral above-knee amputees and bilateral below-knee amputees, including those having serious associated medical conditions, should be given every consideration for possible employment of prostheses.

Bear in mind that this physiatrist was referring to amputees ranging in age from 60 to 70 with serious complicating conditions such as hemiplegia, heart disease, diabetes and tuberculosis.

According to purely utilitarian standards, what could be more futile and unrewarding than applying these expensive restorative technics to such patients?

Yet, medical rehabilitation, as personified by Dr. Cummings, says, "Yes! These patients *are* worthy of all of our skill and devotion."

This is why I say that medical rehabilitation challenges our society by its unswerving determination to maintain the elderly disabled patient at his maximal level of independence and dignity.

### Present System Inadequate

Our society is now faced with the need for providing treatment and rehabilitation facilities which correspond to the needs of our elderly population. Our present system is clearly inadequate to these needs. The over-65 age group is the prime target for diseases which are by nature chronic and disabling. These include heart and vascular diseases, mental illness, arthritis, degenerative diseases, blindness and hearing impairment. However, our medical facilities are linked to a philosophy which for the most part recognizes only two conditions — the curable and the incurable.

This was pointed up by Dr. Herman C. Hilleboe, Health Officer of New York State, in his remarks before the Annual Meeting of the Middle States Public Health Association in Minneapolis in June, 1962. He said:

"The main defect is that we have not geared our resources to the medical care problems of today. . . . Our older people are struck by heart disease, cancer, strokes and other chronic diseases. For these afflictions, they often need to be hospitalized for intensive care during the acute phase of their illness. But once the acute phase of the illness is over, they require prompt rehabilitation. In addition, many of them need long periods of convalescence where less intensive care is required. It is wasteful to treat all these phases in one hospital. Often it is worse than wasteful; it is downright harmful to the patient's welfare."

### Custodial Care

At the other extreme from the general or acute hospital we have the institution dedicated to purely passive care—the custodial or terminal facility, which is an abnegation of our professed belief in the value and dignity of the older person.

Currently there are some 17 million persons over the age of 65 in the United States. Approximately five percent of this number is relegated to institutions, the majority of which are custodial facilities. Background data compiled for the 1960 White House Conference on Aging revealing the following:

"There are about 25,000 nursing homes in the United States, containing about 300,000 beds; 180,000 of these beds are in what are called 'skilled nursing homes' and 80,000 are in personal care homes that provide some skilled nursing care. The remainder of the beds are in personal care homes without skilled nursing care.

"Less than half (of the occupants of these homes) can walk without assistance. Further," this report stated, "care given in most nursing homes and homes for the aged is limited primarily to nursing and custodial care, with no restorative or rehabilitation services. As a result, the great majority of the people in these homes deteriorate physically and mentally to the point of total disability."

There is now an anticipated need for 350,000 additional nursing home beds, based on the expected increase in our geriatric population during the next twenty years.

Surely, we cannot allow this prediction to come to pass!

How can we invalidate this statistical projection?

### What Must Be Done

First, we must renounce the habit of discussing the problems of the aging in terms of future needs for nursing home beds. We must concentrate instead upon the question of how to keep our aging population *out* of these beds. As I have stated before, we must give less emphasis to *habitation* and more to *rehabilitation.*

How can we give our aging citizens the ability to live *outside* of the hospital and *outside* the custodial and terminal facility? And failing this, how can we give them the ability to live with greater dignity and independence, self-respect and hope inside these institutions?

Let us never forget that there are varying degrees of disability, or perhaps it would be better to say varying degrees of independence, each affording its own measure of human comfort and dignity.

There is a great difference between being independent and being *dependent* in such activities as bathing, dressing, eating and walking.

Initially, rehabilitation is more costly than ordinary institutional care. In the long run, however, it is considerably less expensive. Rehabilitation may take weeks, or months—sometimes many months—but passive institutional care can go on and on indefinitely.

The long range economics which can be effected through rehabilitation were well illustrated in the San Mateo, California, study reported in 1961. In this community, a group of aging citizens was given thorough physical examinations at the time they first applied for welfare assistance. Half of these applicants received rehabilitation —corrective surgery, artificial limbs, physical and occupational therapy, and other restorative services, the other half did not. The program was financed by welfare funds. Initially the cost of supplying these services greatly increased welfare expenditures. However, *five years later,* it was found that the total medical care bill for

Continued




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this group was *ten times lower* than for the group which did not receive rehabilitation.

In New York, intensive medical, psychologic, social and economic evaluation of 95 chronically ill hospital patients showed that only seven were in need of continuing hospitalization. Eleven were judged to have a better that 50-50 prospect of successful rehabilitation.

These studies suggest that early initiation of rehabilitation services can keep many patients out of the nursing home, or defer the need for this type of care.

Rehabilitation also has an important and largely unfulfilled function to perform *inside* the nursing home. The full utilization of rehabilitative concepts and technics could do much to vitalize these institutions, and to transform passive, custodial care into active and dynamic service.

We have progressed a long way from the attitude which regards the nursing home as a mere way-station on the road to the grave. At the same time, rehabilitation has progressed far beyond the stage where its exclusive object is re-employment of persons having *vocational* potential.

Medical rehabilitation is moving toward the establishment of a new spectrum of services for the *elderly* disabled patient. It's purpose is to bridge the gap between the general hospital and the custodial facility, and to maintain the patient at his maximal degree of independence over the course of his remaining years.

### Steps Toward Rehabilitation

The first stage is the rehabilitation facility operating within the general hospital. At the Jewish Hospital in St. Louis, Dr. Franz U. Steinberg is studying the ability of geriatric patients to live at home. In this program, intensive rehabilitation is carried on simultaneously with intensive medical care for acute conditions. Out of 43 patients studied in this program, 30 were returned to their homes. With the exception of those who died or suffered a new episode of acute disease, these patients were still at approximately the same level of adjustment after one year.

In this respect, the Federal Community Health Services and Facilities Act of 1961 contained a highly significant amendment which modifies the definition of a "rehabilitation facility" as it applies to eligibility for Hill-Burton funds. This was pointed out by U. S. Surgeon General Dr. Luther D. Terry in an address before the American Congress of Physical Medicine and Rehabilitation.

"Formerly," Dr. Terry explained, "such facilities were required to provide evaluation and services of four types—medical evaluation, psychologic, social and vocational. The new definition calls for the provision of medical services *plus one* of the other three types."

Dr. Terry emphasized that "a major purpose of this amendment was to make Hill-Burton funds available for building and equipping more physical medicine and rehabilitation departments *in hospitals.*" He predicted that "the pattern of the future will combine a small number of comprehensive (rehabilitation) facilities for a state, with a *larger* number of local, medically-oriented, non-comprehensive facilities."

A second step toward bridging the gap between the general hospital and the custodial facility is the establishment of home-care programs. New York's Montefiore Hospital has done some of the early pioneering work in this field. A group from this institution made the following interesting comment on some of their findings:

"Who, indeed, could have predicted that patients apparently incapable of rehabilitation in the hospital would attain major rehabilitation goals in the seemingly less favorable home setting? Nonetheless, for some of our patients such has been the course of events.

"The opportunity to hold on to things physically has its psychological equivalent. More than one elderly patient, able to maintain his orientation at home, has collapsed into confusion in the hospital setting."

In the area of home care, the Community Health Services and Facilities Act of 1961 again offers positive opportunities for action.

This act expanded the Public Health Service's program of matching grants to

states for serving the chronically ill. It also provided for new "project grants" to improve community health services, with special emphasis on the chronically ill and the aged. Both programs stress *out-of-hospital* services. Whereas in the past, states received $1 for each $3 of Federal funds for *general* health programs, the Public Health Service can now allow increased appropriations for programs specifically dedicated to the chronically ill and the aged.

At the end of the spectrum of services for the elderly disabled patient lies the custodial facility. But once more the introduction of medical rehabilitation services is demonstrating that patients can be maintained at the maximal degree of independence and dignity. The results of a program reported by Dr. David Rubin of the Mount Sinai Rehabilitation Hospital in Los Angeles, California, are most heartening in this respect. Dr. Rubin's experience was gained in an institution which was literally converted from a custodial hospital to a rehabilitation center. The results of this program suggest that many of the patients admitted for custodial care can, with intensive medical rehabilitation, return home or be maintained at a high degree of independence in an institution.

To summarize, medical rehabilitation is demonstrating that the elderly disabled patient is capable of attaining varying degrees of independence short of complete custodial care. Medical rehabilitation is demonstrating on a small scale what *can* be done and what *should* be done. The question of what *will* be done rests with individual families and with our voluntary and governmental agencies.

The answer will be based upon the depth and sincerity of our society's belief in the value and dignity of the aged individual.

It is significant that many of the studies I have cited have been conducted under the auspices of Jewish organizations. It is probably not surprising that much of the pioneering work in this field has been encouraged by a cultural group with a strong and deep-lying tradition of family centered care of the aging and with an unquestionable veneration for the aged. This emphasizes the assertion that our ultimate response to the needs of the aging will spring from the *personal* values and beliefs of our society.

I believe that it is the duty of the medical profession, especially those physicians engaged in rehabilitation of the aging, to counsel and guide families in a way that will encourage them to live up to the highest humanitarian ideals of our society. ◄

## DO YOU HAVE A HEMOPHILIAC PATIENT?

**The Indiana State Chapter of the National Hemophilia Foundation is seeking information as to the number of hemophiliacs in Indiana. Medical practitioners throughout the state treating hemophiliac patients are urged to send the names, ages, addresses and details of the type of hemophilia of such patients to Mr. S. T. Friedman, Secretary of the Medical Advisory Council of the Indiana State Chapter of the National Hemophilia Foundation, 3946 Washington Blvd., Indianapolis 5.**

*Medicine At Law*

# DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

*Surgeon's Own Admissions Alone Sufficient to Take Suit To Jury*—In a suit by a patient against a surgeon, admissions made by the surgeon in his testimony would warrant a finding that the patient's injuries were caused by his negligence and this evidence alone was sufficient to take the case to the jury, the Supreme Judicial Court of Massachusetts ruled. The evidence of the surgeon's negligence which was supplied by his own admissions did not have to be corroborated by expert testimony. It would not change this rule which had been applied in many decisions, the court said.

*Manzoni v. Hamlin,* 202 N.E.2d 264 (Mass., Oct. 29, 1964).

*Chiropractors Not Permitted to Take Blood Samples in West Virginia*—An opinion has been issued by the West Virginia Attorney General stating that the state's law does not permit chiropractors to take blood samples from their patients for analysis. The chiropractors had asked the West Virginia Medical Licensing Board for permission to take samples. In the opinion it was also noted that chiropractors are not qualified to testify on medical subjects in personal injury actions in the state.

*Doctor's Statement Protected by Qualified Privilege*—A trial court erred in refusing to dismiss a suit against a doctor for damages sustained by a man as the result of an allegedly libelous statement made about him in a report submitted by the doctor in his professional capacity, a New York intermediate appellate court ruled. Since the statement was made in a professional report, it was qualifiedly privileged. The man failed to sustain his burden of proving that the report was made with actual malice, which would remove it from the protection of the privilege. In fact, the evidence gave rise to the contrary inference that the doctor was not motivated by actual malice in making the report, the court said.

*Gould v. Broad,* 254 N.Y.S.2d 190 (N.Y., Nov. 9, 1964).

*Texas Court Holds Surgeon Liable for Nurse's Negligence Under "Captain of the Ship" Doctrine*—The parents of a nine-year-old child who died from injuries received when, in the course of an operation to clear a block which prevented him from breathing through his nose, ether exploded as the result of the negligence of a nurse employed by the hospital were entitled to recover damages from the surgeon who performed the operation, even though the surgeon himself was not negligent, a Texas intermediate appellate court ruled. Although the nurse was in the general employment of the hospital, she was, while in the operating room, in the special employment of the surgeon and under his control. In the operating room, the surgeon is the "captain of the ship" and is fully responsible for the results of the acts of all persons assisting him in the operation. Damages in the amount of $15,000 were awarded to the parents. Tyler, Texas, December 18, 1964.

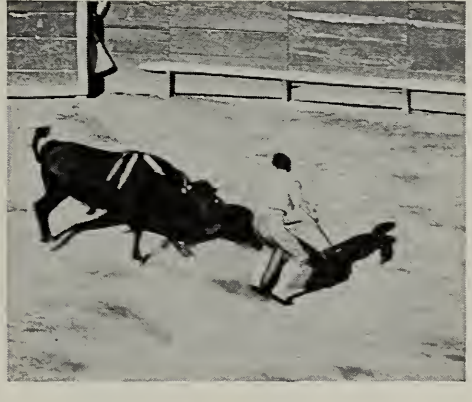
*Hospital and Surgeons not Liable for Shoulder Injury During Surgery*—No liability was found against a hospital and three surgeons who participated in an operation on a 43-year-old patient. The patient was under operation for a period of seven



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Continued

hours to stop internal bleeding through varicose veins. After the operation, the patient was found to have a dislocated shoulder and an injured ulnar nerve. Defense testimony asserted that the patient had suffered a grand mal seizure which had necessitated restraint.

A verdict of not guilty in favor of the three surgeons was directed after the close of all the evidence. A jury returned a verdict in favor of the hospital.

*Reiser v. Presbyterian-St. Luke's Hospital,* Cir. Ct., Cook Co., Docket No. 61S-6605 (Ill., Nov. 20, 1964).

*Use of Medicine-Dispensing Machines Barred in Georgia Hospitals*—The Attorney General of Georgia has issued an opinion stating that the use of mechanical medicine-dispensing devices in hospitals of any category is contrary to the statutes of Georgia and violates the entire spirit and intent of the pharmacy laws of the state.

The Attorney General stated the following as the principal objections to the use of the machines: (1) The prescription would not be personally handled by the registered pharmacist on hospital duty. (2) A nurse would secure the prepurchased dosage from the machine and administer it to the patient. (3) Patient-personalized labeling data, which is required by law, would be omitted.

*No Negligence in Sale of Prednisone*—A suit by a patient against a retail druggist for damages in excess of $200,000 for alleged negligence in the sale of prednisone was dismissed by a trial court in Toronto, Ontario. The patient charged that she contracted ulcers, abnormal growth of hair, and other afflictions after taking the drug for asthma. The court ruled that the patient was "the author of her own misfortune" since she continued to use the drug after her doctor had warned her not to. ◄

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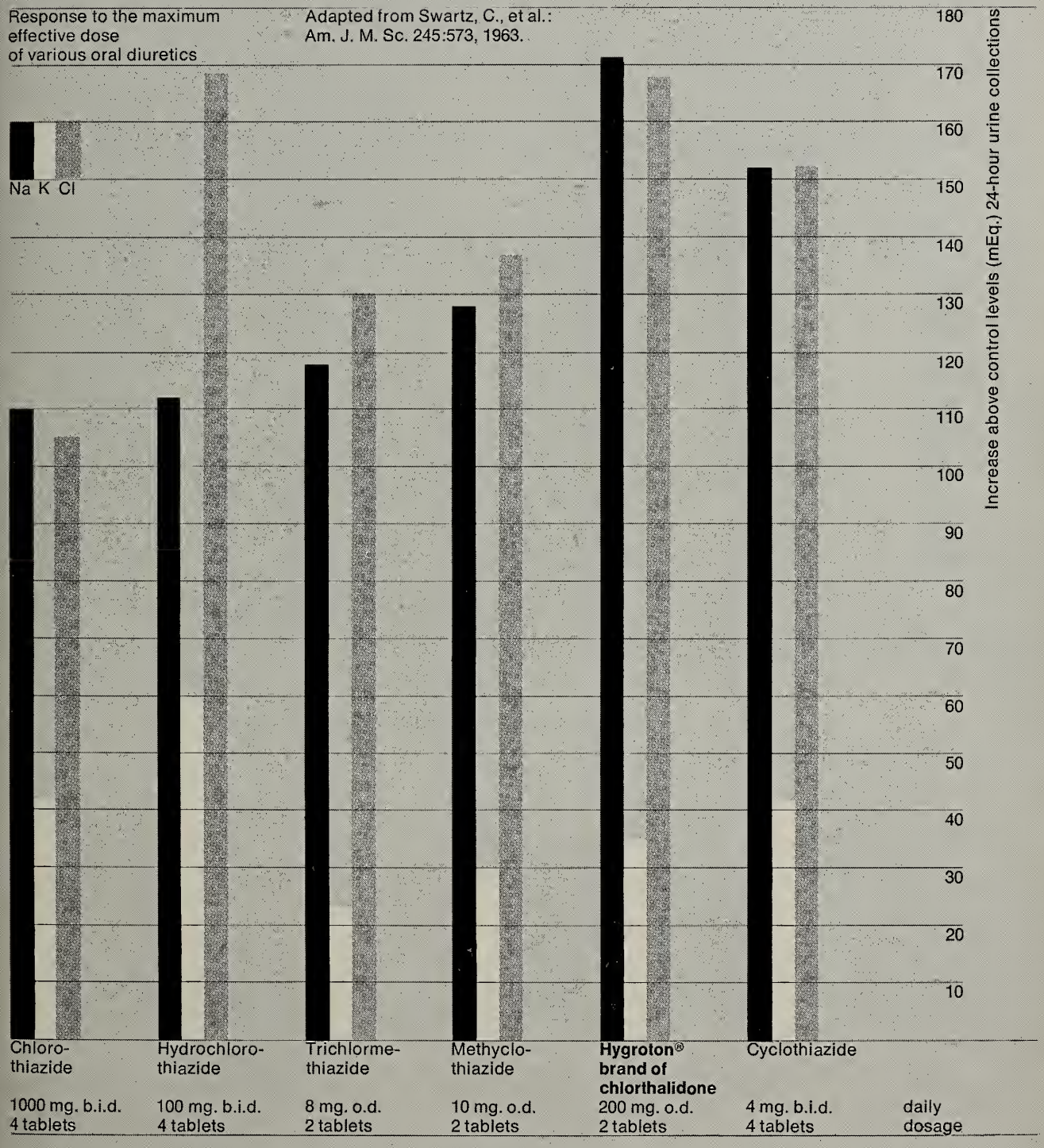
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Side Effects: Constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, leukopenia, muscle cramps, nausea, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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# Blue Shield Operational Data: 1946-1964

*(One of a series prepared by Blue Shield)*

A review of the following table of Blue Shield operational data covering the 18 years of the plan's existence shows continuing growth and continuing economy of operation. In 1964 new records were established in the total number of members, the amount paid for member's doctor bills and the volume of medical claims. Efficient administration reduced our operating cost ratio to 6.6% of each income dollar, the lowest ever.

| | Enrollment At Year End | Number of Claims | Payment For Doctor's Services | Operating Percent |
|---|---|---|---|---|
| 1946 | 80,568 | 540 | $ 32,021 | 30.9% |
| 1947 | 141,293 | 5,780 | 421,479 | 16.4 |
| 1948 | 232,103 | 14,191 | 872,986 | 15.4 |
| 1949 | 364,550 | 27,068 | 1,430,854 | 14.0 |
| 1950 | 539,712 | 47,613 | 2,418,466 | 12.8 |
| 1951 | 729,897 | 78,752 | 3,791,691 | 13.7 |
| 1952 | 871,726 | 109,897 | 5,041,642 | 11.6 |
| 1953 | 989,344 | 144,016 | 6,064,876 | 12.3 |
| 1954 | 1,059,837 | 171,013 | 6,681,876 | 12.5 |
| 1955 | 1,267,994 | 209,510 | 7,945,040 | 11.1 |
| 1956 | 1,355,097 | 291,080 | 11,148,990 | 9.9 |
| 1957 | 1,396,368 | 368,470 | 13,753,780 | 9.7 |
| 1958 | 1,306,181 | 390,975 | 13,730,466 | 9.6 |
| 1959 | 1,363,882 | 427,149 | 14,477,628 | 9.8 |
| 1960 | 1,391,624 | 463,057 | 15,752,605 | 9.0 |
| 1961 | 1,431,251 | 514,991 | 17,957,496 | 8.3 |
| 1962 | 1,469,670 | 587,213 | 20,721,436 | 7.2 |
| 1963 | 1,491,827 | 662,710 | 23,319,855 | 6.8 |
| *1964 | 1,520,148 | 727,020 | 25,846,611 | 6.6 |

* 1964 figures before final audit.

**GRAND TOTALS**

**1946 Through December 1964**

| | |
|---|---|
| Total Payments For Doctors Services since September, 1946 | $191,366,760 |
| Add Outstanding | 3,259,473 |
| Total Claims Expense Through December 31, 1964 | $194,626,233 |
| Earned Income $222,438,468 | |
| Reserve - December 31, 1964 $7,753,495 | |
| Total Claims Paid For Members Since September, 1946 | $5,241,045 |

W. C. Huddlestone
Public Relations Division

# Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1965 annual meeting of the Indiana State Medical Association, Oct. 12-14 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

---

## Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

_____

# ABSTRACTS

## BOOK REVIEWS

### BASIC OTOLARYNGOLOGY

David A. Dolowitz, M.D., McGraw-Hill Book Co., New York, N. Y., 1964; 383 pages; numerous illustrations; exhaustive bibliographies; $12.50.

The author very consciously and specifically aims at the *non-expert* student and general practitioner who has to deal with otolaryngological problems. What can this practitioner do on his own? When may he need the aid of the expert?

My reaction to the book is somewhat colored by my having been a general practitioner who went on to become an internist. Some parts of the book I found very elementary, indeed. Much of the more recent work I found to be new and very informative. In any case, the author eschews the extremely technical and does seem to approach his avowed goal of presenting the elements of his specialty simply and understandably.

The binding is excellent, printing is good and typographical errors limited to the irreducible minimum. Thus, in the preface, third line from the very end, *grammar* is meant where *grammer* is printed; the adjective of vestibule is *vestibular* and not vestibulan. These are picayune items in no way detracting from the overall value of the book.

This book will have a very special niche in the library of many doctors; it can be very definitely recommended.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

## Abstracts From Various Literature, Prepared by AMA

### CARCINOMA OF COLON AND ILEUM IN CHRONIC ULCERATIVE COLITIS WITH REFLUX ILEITIS

C. H. Brown, R. J. Diaz, and W. M. Michener (2020 E. 93rd St., Cleveland).

*Gastroenterology* 47:306 (Sept.), 1964.

A 16-year-old boy who had ulcerative colitis for 12 years was subjected to colectomy because of lack of growth. At operation, multiple carcinomas of the colon and a carcinoma of the ileum associated with reflux ileitis were found. The earlier age incidence of carcinoma and the multicentric origin when associated with ulcerative colitis are well illustrated by this case. The association of carcinoma and inflammatory disease of the small bowel is rare. The association of carcinoma of the


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where vascular insufficiency may cause such symptoms as mental confusion, diplopia, fatigue, apathy, and behavior problems.



IN PERIPHERAL VASCULAR DISEASES
where ischemia causes muscle distress—pain, spasm, ache, intermittent claudication; also coldness, numbness or ulceration of extremities.

ileum, in the case presented, with the ileal lesion of ulcerative colitis is unique and should make one more aware of this possibility.

## TREATMENT OF LEPROSY WITH GRISEOFULVIN

J. Ramos e Silva (Policlinica Geral, Rio de Janerio, Brazil)

*Hospital* 66:1 (July), 1964.

Griseofulvin was administered to two patients affected by leprotic skin lesions treated for years with various drugs that failed to improve the condition. The results showed that griseofulvin, given at a dosage of 500 mg daily, deactivated the existing lesions and inhibited the appearance of new ones. Perfect tolerance to the drug and improved general conditions occurred in both patients, although no effect on neuritis and no modification of bacilloscopy were noted.

## THE CASE FOR ANTICOAGULANT THERAPY

I. S. Wright (525 E. 68th St., New York)

*Circulation* 30:447 (Sept.), 1964.

This is a comprehensive survey of the results of anticoagulant therapy for myocardial infarction and its thromboembolic complications. The reports from investigators from other countries indicate that the great majority has obtained favorable results. With this form of treatment during the first one to three months, the death rate has been reduced one-third to one-half and the thromboembolic complications four-fifths, on the average. Most long-term studies have shown that the mortality can be reduced significantly during the first two years. Reasons for differences in a few studies are discussed. More well controlled long-term studies are needed.

## PIGMENT DEPOSITION IN VISCERA ASSOCIATED WITH PROLONGED CHLORPROMAZINE THERAPY

A. C. Greiner and G. A. Nicolson (Crease Clinic of Psychological Medicine, Essondale, B. C.)

*Canad. Med. Assoc. J.* 91:627 (Sept. 19), 1964.

Twelve physically healthy young adult mental hospital patients died unexpectedly while on prolonged chlorpromazine therapy. Five of them had clinically obvious pigmentation of the exposed skin. Two of these had impairment of vision as well. Autopsies were performed on all 12 patients. Extensive deposits of pigment (exhibiting the physical and histochemical properties of melanin) were present in macrophages in the dermis and through the reticuloendothelial system, and in the parenchymal cells of internal organs. The dopa tyrosinase reaction indicated increased melanocyte activity in the epidermis. The possible mechanism of production of this pigment is discussed, and the belief is expressed that the increased melanin production is due, at least partly, to the effect of chlorpromazine on the autonomic nervous




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where decreased blood flow results in hearing loss (sudden onset), tinnitus, and vertigo.

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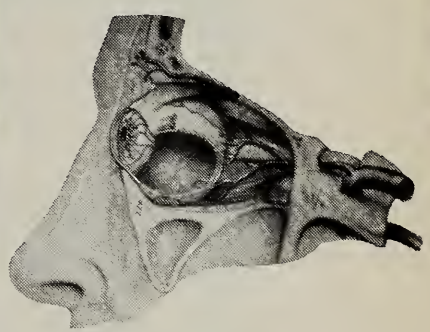
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system, blocking the production of pigment-lightening factors, of which melatonin is the most important.

## THERAPY OF CHLORPROMAZINE MELANOSIS

A. C. Greiner, G. A. Nicolson (Crease Clinic of Psychological Medicine, Essondale, B. C.), and R. A. Baker

*Canad. Med. Assoc. J.* 91:636 (Sept. 19), 1964

Chlorpromazine-induced melanosis has become a serious problem in mental institutions. Skin pigmentation is cosmetically undesirable. Ocular deposits have produced visual impairment. Diffuse visceral involvement has led to many functional disturbances. Withholding chlorpromazine in eight patients with this type of melanosis did not diminish the pigment deposits already present. Therefore, therapy for existing cases and means of preventing this side effect were investigated. A method of blocking melanin synthesis by depressing tyrosinase activity was devised. A copper chelating agent, D penicillamine, was administered for a period of four weeks. Four of six patients thus treated improved markedly, as evidenced by diminution of skin pigmentation. Urinary copper excretion was substantially increased during the trial period. An alternative method of treatment designed to stimulate melatonin production by the pineal gland was employed. Two patients were kept in darkness for a period of four weeks. One improved markedly, the other only slightly.

## THE INCIDENCE OF POSTOPERATIVE JAUNDICE WITH SPECIAL REFERENCE TO HALOTHANE

J. C. Henderson and R. A. Gordon (Department of Anaesthesia, Toronto General Hosp., Toronto) *Canad. Anaesth. Soc. J.* 11:453-459 (Sept.), 1964.

A retrospective study of 250 cases of postoperative jaundice following the administration of 92,920 general anesthetics during the two periods 1953 to 1956 and 1960 to 1963 at the Toronto General Hospital revealed a marked increase in the over-all incidence, but no significant difference between those anesthetized with halothane and those anesthetized with other agents.

## STRIP-PACKED MEDICINES CUT HOSPITAL'S DISPENSING ERRORS

J. Mack Davis, Jr. (Freeman Hosp., Joplin, Mo.) *Mod. Hosp.* 103:118-120, (Nov.), 1964.

Strip-packed tablets and capsules have successfully survived their first year at a 129-bed hospital. The advantages of strip-packed medicines outweigh the problems. Strip-packed medicines usually come in either rolls or sheets. A roll is a long strip of cellophane containing 100 doses while a sheet is in the shape of the standard typewriter page and contains 20 doses. In addition, some manufacturers wrap capsules individually in singles. ◀

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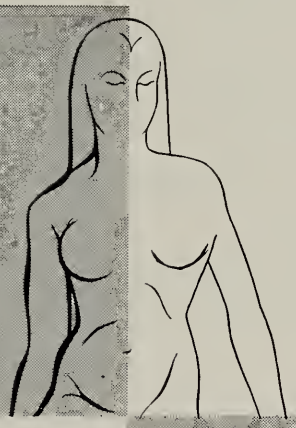
## MONTHLY REPORT—January, 1965

| Disease | Jan. 1965 | Dec. 1964 | Nov. 1964 | Jan. 1964 | Jan. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 283 | 403 | 603 | 340 | 235 |
| Chickenpox | 890 | 766 | 404 | 676 | 1132 |
| Conjunctivitis | 139 | 123 | 77 | 128 | 67 |
| Diphtheria | 1 | 0 | 0 | 0 | 0 |
| Dysentery, Unspecified | 42 | 99 | 28 | 113 | 533 |
| Gonorrhea | 319 | 349 | 299 | 250 | Not Available |
| Impetigo | 103 | 133 | 95 | 96 | 67 |
| Infectious Hepatitis | 29 | 38 | 28 | 44 | 41 |
| Infectious Mononucleosis | 40 | 63 | 52 | 14 | 26 |
| Influenza | 612 | 820 | 665 | 1402 | 1314 |
| Measles (Rubeola-Rubella) | 209 | 188 | 130 | 1249 | 654 |
| Meningitis, Meningococcal | 5 | 5 | 5 | 4 | 9 |
| Meningitis, Other | 3 | 8 | 9 | 8 | 4 |
| Mumps | 324 | 652 | 287 | 677 | 503 |
| Pertussis | 28 | 33 | 22 | 15 | 49 |
| Pneumonia | 291 | 261 | 238 | 237 | 245 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 0 |
| Streptococcal Infection | 577 | 611 | 426 | 400 | 642 |
| Syphilis | | | | | |
| Primary & Secondary | 3 | 5 | 9 | 12 | Not Available |
| All Other Syphilis | 90 | 84 | 101 | 94 | Not Available |
| Tinea Capitis | 30 | 45 | 11 | 4 | 28 |
| Tuberculosis (Active) | 86 | 81 | 87 | 62 | 118 |


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# Annual Meeting Dates of Professional Medical and Allied Organizations

**AMERICAN MEDICAL ASSOCIATION CONVENTION**
Date June 20-24, 1965
Place New York, N. Y.

**AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER**
Date May 2-5, 1965
Place Aboard the Delta Queen Riverboat, leaving from Cincinnati, O.

**BONE AND JOINT CLUB**
Date April 14, 1965
Place The Athenaeum, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 19, 1965
Place Indianapolis

**INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS**
Date May 15, 1965
Place Indianapolis Athletic Club

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 12-14, 1965
Place Murat Temple, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

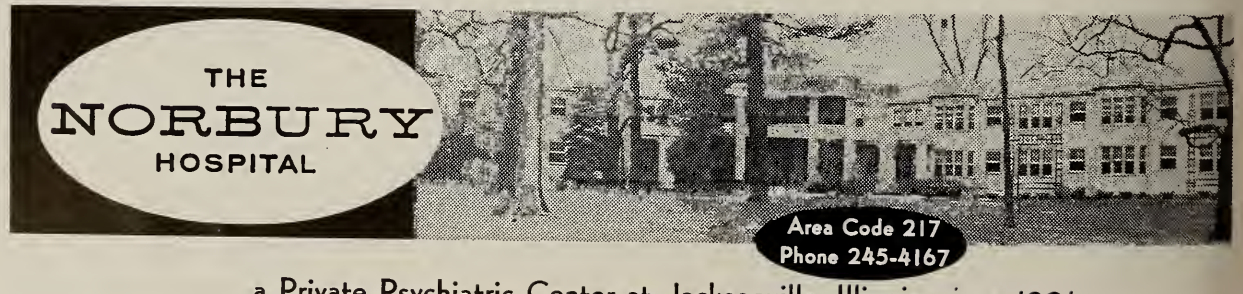
**INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**
Date May 7-8, 1965
Place Oakbrook, Ill.

**INDIANA ORTHOPAEDIC SOCIETY**
Date June 25-26, 1965
Place Marott Hotel, Indianapolis

**INDIANA CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS**
Date April 21-22, 1965
Place Marott Hotel, Indianapolis

**INDIANA ROENTGEN SOCIETY**
Date May, 1965
Place Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


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The remarkable efficacy of Robinul (glycopyrrolate) in the treatment of peptic ulcer cannot be attributed to any single characteristic of the drug. Rather it is the sum total of several subtle pharmacologic advantages that enables this anticholinergic to make such a significant contribution to the total ulcer regimen.

Epstein[1] found glycopyrrolate's intensive antisecretory action to be exemplary. Breidenbach[2] was impressed by its pronounced antispasmodic effects. And Young and Sun[3] reported that a 2 mg. oral dose "did not affect gastric emptying or intestinal transit time. . . ." According to Slanger[4], the absence of annoying side effects is an important plus factor ". . . for it permits ready individualization of dosage for control of mild to severe symptoms." Posey[5] sums it up when he says, "In effect, with glycopyrrolate, one approaches an ideal agent for the management of peptic ulcer. With it a vagolytic effect may be obtained without interfering with gastric emptying—the medical equivalent to vagectomy plus an adequate drainage procedure."

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INDICATIONS: In addition to its primary indications for duodenal and gastric ulcer, glycopyrrolate is indicated for other G-I conditions which may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

CONTRAINDICATIONS: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

PRECAUTIONS: Administer with caution in the presence of incipient glaucoma.

SIDE EFFECTS: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

DOSAGE: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day: in the a.m., early p.m., and at bedtime. *See product literature for full prescribing information.*

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phenobarbital 16.2 mg.
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REFERENCES: 1. Epstein, J. H.: Am. J. of Gastroent., 37:295, March, 1962. 2. Breidenbach, W. C.: Investigative Clinical Report, March, 1961. 3. Young, R., and Sun, D. C. H.: Ann. N. Y. Acad. Sc., 99:174, Feb., 1962. 4 Slanger, A.: Journal of New Drugs, 2:215, July-Aug., 1962. 5. Posey, E. L., Jr.: Am. J. Dig. Dis., 7:863, Oct., 1962.

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## *SUMMER CAMP FOR DIABETIC CHILDREN JULY 18-AUGUST 8 IN WISCONSIN*

The summer camp for diabetic children will be conducted for the 17th year under the auspices of the Diabetes Association of Greater Chicago from July 18th through August 8th, 1965 at Holiday Home, Lake Geneva, Wisconsin. Boys and girls from eight through 14 years of age are eligible.

As in previous years, the camp will be staffed by resident physicians, a nurse, two dietitians and a laboratory technician, in addition to the regular counseling and domestic staff of Holiday Home.

Rates for summer camp are arranged in accordance with individual circumstances. Applications may be obtained from and inquiries should be directed to: DIABETES ASSOCIATION OF GREATER CHICAGO, 620 North Michigan Ave., Chicago 60611.

## New Booklet Published

"How To Get Good Medical Care," a 30-page pamphlet written for lay consumption, has just been issued by the Public Affairs Committee. It may be obtained for 25 cents per copy, and for less in quantities, by writing the Committee at 381 Park Ave., South, New York City, 10016.

## *Catalogue of International Medical Meetings Available*

A catalogue of the principle international medical meetings to be held abroad during 1965, together with suggested scientific and sightseeing travel arrangements has been issued by Lee Kirkland of Group Travel Services.

A copy of the booklet may be obtained by writing to Medical Meetings International, Broadway at 34th St., Kansas City, Missouri, 64111. A copy of the 1966 booklet, which will be available later, may be requested now.

## Dr. Sputh Named President

Dr. Carl B. Sputh, Indianapolis, was installed as president of the American Rhinologic Society at its recent annual meeting. Dr. Walter J. Aageson of Anderson was installed as second vice-president.

## *New General Manager*

D. Fred Bledsoe, vice-president for Marketing for the Pitman-Moore Division of the Dow Chemical Company, has been named general manager of the division. He succeeds Russell C. Ludwig who will become General Manager of the chemical firm's Packaging Division with headquarters in Cleveland and plants in ten other locations throughout the country.

A native of Cabool, Missouri, Bledsoe is a graduate of Butler University School of Pharmacy in Indianapolis.

## *Dr. Ashmore Takes Sabbatical Leave*

Dr. James Ashmore, professor and chairman of the Department of Pharmacology, Indiana University School of Medicine is on sabbatical leave for several months.

He will work with Dr. Otto Wieland of the University of Munich, and while abroad will visit England to participate in two symposia. ◄



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# FUTURE MEETINGS, SEMINARS, COURSES

## *ACOG Annual Clinical Meeting Set for April in California*

Members of ISMA are invited to attend the annual clinical meeting of the American College of Obstetricians and Gynecologists to be held at San Francisco on April 4 to 8.

A complete scientific program of round tables, panel discussions, luncheon conferences and scientific and industrial exhibits is planned. For details write the college at 79 W. Monroe St., Chicago 60603.

## American Industrial Health Conference Set for April 5-8

The Industrial Medical Association and the American Association of Industrial Nurses will conduct the American Industrial Health Conference at the Americana Hotel, Bal Harbour, (Miami Beach) Florida from April 5 to 8. Attendance is not limited to the two memberships.

All persons interested in industrial or occupational health may attend. In particular, physicians and nurses, industrial hygienists, safety engineers, health physicists, management and supervisory personnel are invited.

The registration fee is $10.00, except for student nurses, student physicians, interns, residents and exhibitors. Information may be obtained by writing American Industrial Health Conference, 55 E. Washington St., Chicago 60602.


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## *Tri-State Hospital Assembly Will Hold 35th Annual Meeting*

The Tri-State Hospital Assembly, the organization which serves hospitals in the four states of Indiana, Illinois, Michigan and Wisconsin will hold its 35th annual meeting at the Palmer House in Chicago on April 26 to 28. The program will contain instructional presentation on all phases of hospital administration.

## Good Samaritan Hospital Sets Seminar on Premature Care

The Good Samaritan Hospital, Cincinnati, Ohio, has announced the third annual seminar on Premature Care to be held on April 15, from 1:00 to 6:00 p.m.

There are no registration fees but physicians planning to attend are requested to contact James J. Englert, M.D., Chairman, Premature Seminar, Good Samaritan Hospital, Cincinnati, Ohio, for reservations.

## American Ob-Gyn Board Lists Dates of Part II Exam

The Part II examination will be conducted by the American Board of Obstetrics and Gynecology at the Edgewater Beach Hotel, Chicago, Illinois April 26-May 1. Candidates scheduled for examination are urged to make their hotel reservations at an early date.

Applications for the Part II examination to be given in April of 1966 will be accepted in the office of the secretary during April or May, 1965 and must be accompanied by duplicate lists of patients dismissed from their service during the 12 months immediately preceding date of application.

## *Hahnemann Medical College Lists Postgraduate Courses*

Postgraduate education courses sponsored by the Hahnemann Medical College and Hospital are as follows: April 26-29, 14th Hahnemann Symposium on Mechanisms and Therapy of Cardiac Arrhythmias; July 26-30, Interpretation and Therapy of Cardiac Arrhythmias; November 22-24, 15th Hahnemann Symposium on Cancer Chemotherapy: Basic and Clinical Applications; December 8-10, A Hahnemann Symposium—New Concepts in Gynecological Oncology; April 20-23, 1966, 16th Hahnemann Symposium on Arterial Occlusive Disease and December, 1966, 17th Hahnemann



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| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
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## FUTURES

Continued

Symposium on Nutritional Dysfunction.

### *Postgraduate Seminar in Rheumatic Diseases in April*

A Postgraduate Seminar in Rheumatic Diseases will be held in the Rankin Ampitheater at Louisville General Hospital on April 15. New concepts in rheumatology have been evolving in recent years and this seminar has been designed to highlight those new advances in diagnosis and treatment which may aid in solving difficult clinical problems in rheumatoid arthritis.

A series of lectures covering various aspects will be followed by panel discussions emphasizing clinical applications. The seminar will be sponsored by the Kentucky Arthritis Foundation and the University of Louisville School of Medicine. Detailed information about the seminar may be obtained from the Kentucky Arthritis Foundation, 209 Speed Building, Louisville, Kentucky.

### Cleveland Clinic Announces Course on Thyroid Diseases

The Cleveland Clinic Educational Foundation will present a postgraduate course entitled "Recent Advances in the Diagnosis and Treatment of Thyroid Diseases" April 14-15 at Cleveland.

Registration fee is $30.00. Further information on the course may be obtained by writing the Educational Secretary, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

### Seminar Scheduled on Chronic Obstructive Lung Disease

A one and one-half day seminar on Chronic Obstructive Lung Disease will be presented May 1 and 2 at the Medical College of Georgia, Augusta. Five nationally known teachers will discuss recent developments related to this problem.

A registration fee of $5.00 will be charged. Information concerning details of the program, registration, etc., may be obtained by writing to the Department of Continuing Education, Medical College of Georgia, Augusta, Georgia.

### *Dr. Nelson to Present Lectures on Diagnostic Radiology*

Dr. Sidney Nelson, Professor and Chairman, Department of Radiology, Ohio State University, Columbus, Ohio, will deliver the 17th annual Joseph and Samuel Freedman Lectures in Diagnostic Radiology at the University of Cincinnati College of Medicine on June 24 and 25.

Radiologists desiring to attend are requested to write Dr. Benjamin Felson, Department of Radiology, Cincinnati General Hospital, Cincinnati, Ohio 45229, for further details. ◄


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A hospital for the treatment of Neuro Psychiatric Disorders

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# County News

## Allen

Dr. Marjorie E. Conrad spoke on "Physical and Psychological Care of the Adolescent" at the Feb. 2 meeting of the Allen County Medical Society. There were 115 physicians and their wives at the meeting.

## Cass

Speakers at the Feb. 1 meeting of the Cass County Medical Society were Jerry Ginthner, director of the Logansport Chamber of Commerce and Jim Coplen, president of the National Bank of Logansport. Their topic was "Industrial Planning." There were 34 members present.

## Clark

Dr. Joseph P. Mudd is the new president of the Clark County Medical Society. Other new officers include: Drs. David H. Jones, vice-president; Clemente F. Oca, secretary-treasurer; Joel Carney, delegate and Ralph Bruner, alternate.

## Clinton

Dr. E. K. Williams spoke on "Regional Enteritis" at the Jan. 26 meeting of the Clinton County Medical Society. There were 13 members present.

## Daviess-Martin

New officers of the Daviess-Martin County Medical Society are: Drs. A. G. Blazey, president; L. M. McNaughton, vice-president; C. P. Fox, secretary-treasurer; A. G. Blazey and E. B. Lett, delegates and M. H. Seat and R. E. Chattin, alternates.

## Dearborn-Ohio

Mr. Clayton Scroggins discussed "Medical Economics and Office Management" with the members of the Dearborn-Ohio County Medical Society at its Feb. 4 meeting.

## Elkhart

Professor Robert Garrett spoke at the Feb. 4 meeting of the Elkhart County Medical Society. His topic was "Obstructive Phenomena in Infants and Children."

## Fayette-Franklin

The Fayette-Franklin County Medical Society met Feb. 9 to hear Dr. Charles Fisch, Indianapolis, speak on "Cardiac Pacemakers."

## Hancock

The Hancock County Medical Society has elected the following as its new officers: Drs. Ted C. Kirby, president; Wilbur Beeson, vice-president; John J. Farrell, Jr., secretary-treasurer; Wayne Endicott, delegate and Robert A. Cagle, alternate.

## Hendricks

Dr. Fred Warbinton is the new president of the Hendricks County Medical Society. Other new officers are: Drs. William Stafford, vice-president; Thomas P. Chase, secretary-treasurer; M. O. Scamahorn, delegate and David Haggard, alternate.

## Jefferson-Switzerland

Dr. Merritt Alcorn discussed "The Eye Bank" with the 28 members of the Jefferson-Switzerland County Medical Society present at the Feb. 2 meeting.

## LaPorte

Newly elected officers of the LaPorte County Medical Society are: Drs. E. C. Mueller, president; David P. Morton, vice-president; Peter Pilecki, secretary-treasurer; G. O. Larson and T. D. Armstrong, delegates and J. C. Richter and Amos Arney, alternates.

## Ripley

Dr. R. Lee Smith has been re-elected president and Dr. William J. Warn secretary-treasurer of the Ripley County Medical Society. Delegate will be Dr. William E. Freeland and alternate will be Dr. Lloyd W. Hisrich.

## Rush

Officers of the Rush County Medical Society

Continued on page 280

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to Home Lawn Mineral Springs for a few days health vacation —the mineral baths and excellent meals in an atmosphere of serenity will leave your cares behind and play golf on a beautiful course.



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The large variety of bacterial infections peculiar to the respiratory tract with their often acute episodes requires an antibiotic that combines broad-spectrum effectiveness with prompt, dependable serum levels. In addition to these benefits, Terramycin Intramuscular Solution is generally well tolerated at the injection site. All three advantages are dramatically illustrated in a study[1] of 119 children severely ill with a variety of bronchopulmonary infections. In this study, in which rapid, high levels were needed to initiate treatment, results were recorded as good in 107 and fair in 12. Terramycin Intramuscular Solution was used initially; oral Terramycin was used for follow-up therapy.

Terramycin Intramuscular Solution has proved a valuable component of total antibiotic therapy. Moreover, only Terramycin, among the broad-spectrum antibiotics, is available as a *preconstituted* solution for I.M. use. Always ready for immediate injection, it requires no refrigeration and remains stable for at least two years. This is one of a wide range of practical dosage forms for virtually every therapeutic need in the treatment of susceptible respiratory tract infections.

No other single broad-spectrum antibiotic has been more widely employed in such a great variety of infections—common or difficult—caused by gram-positive or gram-negative bacteria, spirochetes, rickettsiae, protozoa and large viruses, as well as bacteroids and *Enterobius vermicularis.*

Ahead of its time for 14 years, Terramycin remains a broadly effective and dependable antibiotic with a fine record—confirmed by more than 6,000 published papers. Moreover, the incidence of serious adverse effects has been remarkably low

1. Nathan, L. A.: Exhibit presented at Mich Acad. Gen. Pract., Detroit, Mich., Nov. 10-12, 1961

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**Warning:** Reduce usual dosage and consider antibiotic serum level determinations in patients with impaired renal function. Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth.

**Precautions:** Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

All precautions applicable to intramuscular injection should be carefully observed. Intramuscular solutions should be injected well within the body of a relatively large muscle, such as the upper outer quadrant of the buttock or the lateral thigh; do not inject into the lower or middle thirds of the upper arm. Care should always be taken to avoid injecting into a blood vessel or major nerve. Subcutaneous or fat-layer injection should be avoided.

**Adverse Reactions:** Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

**Supply:*** Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc. Terramycin (oxytetracycline) Intramuscular Solution: available as ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

*All potencies listed are in terms of the standard, oxytetracycline

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## COUNTY NEWS

Continued

for 1965 are: Drs. Harry G. McKee, president; Marvin C. Schneider, vice-president; Charles E. Sheets, secretary-treasurer and Frank H. Green, delegate.

### Vanderburgh

The Vanderburgh County Medical Society joined the First District Academy of General Practice in its annual road show program Feb. 4. Speakers were Dr. Harold Houser, of Western Reserve University School of Medicine and Dr. J. S. Battersby, I. U. School of Medicine.

### Wabash

Dr. C. D. Gatzimos is the new president; Dr. John R. Dragoo the new vice-president and Dr. H. H. Dunham the new secretary-treasurer of the Wabash County Medical Society.

### Wayne-Union

Dr. Paul Runge has been elected president of the Wayne-Union County Medical Society. Other officers are: Drs. Tom Shields, vice-president; Joseph Zore, secretary; Alois Gibson, treasurer; C. G. Clarkson and Glen Ward Lee, delegates and Frank Lewis and Tom Shields, alternates.

### Whitley

Representatives of Lederle Laboratories met with the Whitley County Medical Society Feb. 9 to discuss the oral polio immunization program. ◄


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PAULINE L. TOOILL, R.R.L.
*Medical Record Librarian*

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*Director of Nurses*

ANN HARPER, B.S., O.T.R.
*Occupational Therapist*

JAMES MYERS, B.S., M.Ed.
*Recreational Therapist*

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# Deaths

### Orris T. Allen, M.D.

Dr. Orris T. Allen, 85, retired otolaryngologist, died Nov. 14, 1964 at Terre Haute.

A member of the Vigo County Medical Society and the ISMA 50-Year Club, Dr. Allen was graduated from the Northwestern University School of Medicine in 1909. He was certified by the American Board of Otolaryngology and had retired in 1963.

### F. L. Hade, M.D.

Dr. Frederick L. Hade, retired Indianapolis physician, died Jan. 24 in his home. He was 81.

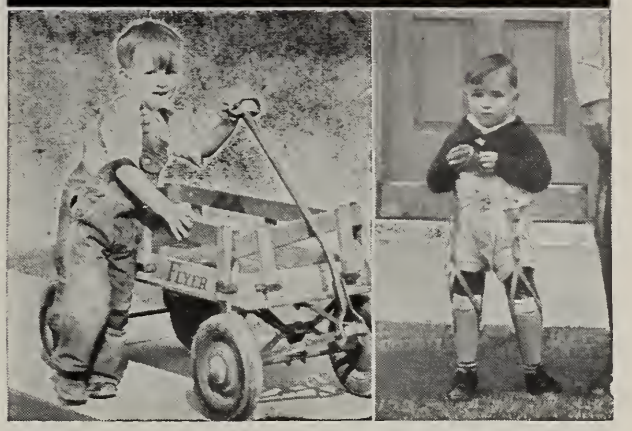
Member of the staff at Methodist Hospital until he retired six years ago, Dr. Hade was a 1912 graduate of the old American College of Medicine and Surgery, now Loyola University. He was a member of the Marion County Medical Society and the ISMA 50-Year Club.

### David L. Lutes, M.D.

Dr. David L. Lutes, 78, Edinburg physician, died Jan. 19.

A 1911 graduate of the Indiana University School of Medicine, Dr. Lutes was a member of the Johnson County Medical Society and the ISMA 50-Year Club. ◄


"... he runs and plays again!"



Hanger Prosthetic Appliances have brightened the present and the future for many amputees. For example, Weaver Nolt says: "My son, Lloyd, was a pathetic figure in a big hospital bed after his legs were amputated because of an accident. Today it's a big and wonderful world again as he gets along so wonderfully on his Hanger legs. He walks without any help, and runs and pushes his wagon all over the farm. That other day is just a hazy memory, and we are so pleased things are so different than we expected.

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## SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 12-14, 1965, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

_____

_____

Name_____

Address_____

City_____

State_____

# Association News

## EXECUTIVE COMMITTEE

January 23, 1965

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D.; Lester H. Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert Hollowell, attorney, and J. A. Waggener, executive secretary.

### Membership Report:

| | |
|---|---|
| Number of members as of December 31, 1963 | 4,371 |
| 1964 members as of December 31, 1964: | |
| Full dues paying | 3,803 |
| Residents and interns | 133 |
| Council remitted | 48 |
| Senior | 326 |
| Honorary | 3 |
| Military | 52 |
| Total 1964 members as of December 31, 1964 | 4,365 |
| Number of members as of December 31, 1963 | 4,371 |
| Loss over last year | 6 |

| | | |
|---|---|---|
| Number of AMA members as of December 31, 1964 | | 4,256 |
| Total 1963 AMA Members as of December 31, 1963 | | 4,262 |
| Loss over last year | | 6 |
| 1964 AMA members: | Dues paying | 3,694 |
| | Exempt, but active | 562 |
| | | 4,256 |
| Number who have paid state dues but not AMA dues as of December 31, 1964 | | 109 |

### Headquarters Office

The legal counsel and the secretary reported on the activities of the Pharmaceutical Board in filing affidavits against physicians for dispensing drugs. The main question remaining to be ironed out between the Pharmaceutical Board and the association is the dispensing of drugs where a large group of physicians are involved in a common building maintaining a separate drug room. Mr. Hollowell pointed out that under the Pharmacy Act as well as the State Medical Practice Act and Dangerous Drug Act, a physician has a right to compound, supply, dispense or administer drugs. It is evident that there have been some violations in some instances in the labeling procedures which are established by law and which apply to both physicians and pharmacists.

The remaining question to be resolved is that of a large number of physicians operating as a group or a clinic and maintaining a separate drug room in which drugs are counted, or perhaps compounded, by an individual other than a registered pharmacist. The legal counsel pointed out that in his opinion this is within the law so long as the doctor himself or his nurse procures the drug for the patient, but there is a question concerning infringement of the law where the physician might give the patient a prescription, or an order, for the patient to personally take to the drug room and procure the drug. He is of the opinion that so long as the patient is not involved in the procurement of the drug as a third party, these operations are within the law.

The Executive Committee approved Mr. Hollowell's philosophy for future negotiations of this question.

### Building Matters

The proposed agreement between the medical association and the Wil-Ten Company, Inc., for exchange use of parking facilities and a ramp making an egress possible from the association parking lot to Fortieth Street was approved on motion of Drs. Rifner and Larson.

### Treasurer's Office

The treasurer reported on some information he had received concerning the investment of association funds in commercial short term paper rather than government notes. On motion of Drs. Neumann and Larson, it was agreed that the association should not invest in this type of security.

The quarterly audit and statement of condition as of January 1, 1965, were approved by consent.

The budget for the 1965 fiscal year was presented and it was noted, in accordance with the wishes of the Council, the councilors had been advised of the meeting to consider the budget and no councilors were present.

After a full review of the budget, upon motion of Drs. Neumann and Rifner, the budget was accepted as presented.

### Legislation

Discussion of legislation appearing before the Congress and the State Legislature was deferred inasmuch as these matters were to be discussed before the Council on January 24.

### Organization Matters

A letter from the American Association of Blood Banks concerning legislation which might be before the Indiana Legislature was reviewed, together with a report from Dr. Hoyt who attended a meeting upon this subject. Upon motion of Drs. Neumann and Rifner, it was agreed the association would support a bill to place blood banks under the sole direction of medical societies if such a bill were presented to the Indiana Legislature.

The request of the Indiana Association for Mental Health for permission to make an award to a physician for his contribution to the mental health program at the time of the annual convention of the Indiana State Medical Association and also the request that the president appoint two members of the association to serve as judges to select the recipient, were approved on motion of Drs. Larson and Black.

A letter from Dr. Lowell Thomas concerning the rezoning matter was read for the information of the committee.

The request of the Indiana Academy of General Practice for use of the association mailing list was approved on motion of Drs. Neumann and Black.

A letter from Dr. E. S. Jones, delegate to the AMA, was read for the information of the committee.

Request of the Hoosier State Press Association that the association purchase a page ad in its annual convention issue at a cost of $90.00 was approved on motion of Drs. Black and Larson.

A request of the Indiana Youthpower Conference that the association become a member of this group and contribute $50.00 to carry on the work of the conference was approved on motion of Drs. Rifner and Black.

The request of the Commission on Public Information to seek financial support from Merck, Sharp & Dohme to lease a series of television productions entitled, "Doctors at Work," was approved on motion of Drs. Black and Olvey, with one member dissenting.

Actions of the Commissions on Medical Economics and Insurance and Governmental Medical Services were read for the information of the committee.

Letter from the Commission on Public Health requesting the expenditure of $36.00 for the purchase of a book published by the Department of HEW was deferred on motion of Drs. Neumann and Larson.

Letter from the Commission on Public Health dealing with the training of Selective Service rejects was referred to the Council on motion of Drs. Hoyt and Rifner.

A report of the Commission on Public Health, in which the commission recommended that the State Board of Health supply TB medication to physicians for indigent patients was approved on motion of Drs. Larson and Olvey.

Notice of the intent of the Ohio State Medical Association to nominate Charles L. Hudson, M.D., of Cleveland, for the office of president-elect of the AMA in June, 1965, was read for the information of the committee.

A letter from Elvis J. Stahr, president of Indiana University, complimenting the association on the fine program it conducted at Miami during the AMA meeting, was read for the information of the committee.

A letter addressed to *The Indianapolis Star* by M. H. Crabb, M.D., secretary of the Federation of State Medical Boards of the United States, taking issue with an article which appeared in *The Star* concerning the operation of the State Board of Medical Registration and Examination, was read for the information of the committee.

Request of the Colorado Diabetes Association to use the mailing list of the association to announce a postgraduate program was approved by consent.

A letter from C. H. Maxwell, M.D., secretary of the Second National Conference on Cardiovascular Diseases, in which was proposed the organization of a planning committee in Indiana and a grant of $500.00, was referred to the Commission on Voluntary Health Agencies for study, on motion of Dr. Rifner and taken by consent.

A letter from Lake County concerning the hospital problem in that county was read for the information of the committee. On motion of Drs. Larson and Hoyt, the president was authorized to appoint a special committee to call on Dr. Offutt to discuss this question as it relates to hospital licensing laws in the State of Indiana.

Minutes of the meetings of the Board of Directors and the Executive Committee of Mutual Medical Insurance, Inc., were reviewed for the information of the committee.

### The Journal

Dr. Ramsey reported on some of the activities in *The Journal*, and optimism for the financial outcome of *The Journal* for the year was expressed.

### Future Meetings

On motion of Dr. Larson, taken by consent, Dr. Petrich was authorized to represent the association at the Annual Congress on Medical Education in Chicago, February 6-9, 1965.

Invitation to send representatives to the National Conference on Day Care Services in Washington, D.C., May 13 to 15, 1965, was rejected by consent.

On motion of Drs. Rifner and Larson, Dr. Emmett Lamb was authorized to represent the association at the AMA Congress on Environmental Health Problems in Chicago, April 26 and 27, 1965.

There being no further business, the committee adjourned to meet again at 3:00 p.m., Saturday, February 13, 1965.

## EXECUTIVE COMMITTEE

January 24, 1965

The Executive Committee convened following the close of the Council meeting and reviewed the resolutions adopted by the Council for submission to the special meeting of the American Medical Association House of Delegates and authorized certain changes in these resolutions to meet with the desires of some of the delegates.

There being no further business, this meeting was adjourned.

## TELEPHONE CONFERENCE, EXECUTIVE COMMITTEE

January 25, 1965

A special telephone conference with the Executive Committee was held at 6:00 p.m., January 25. Included in the conference was Dr. Lester D. Bibler.

The secretary reported that he had called the

conference inasmuch as he was receiving some objections to the resolutions adopted by the Council being mailed to AMA delegates prior to the special meeting of the AMA House of Delegates on February 6 and 7. Also, he was led to believe that the wording of the resolutions was contrary to the recommendations which were to be made by the board of trustees to the house and was contrary to recommendations made by some of the councils of the AMA. Dr. Bibler was requested to discuss this with the members of the Executive Committee.

Dr. Bibler did go into a detailed discussion of the pros and cons of this issue and felt that it would be wiser for the association to prepare the resolutions, having them ready for introduction, if indicated, at the special meeting rather than to submit them in advance to the AMA and the members of the house.

Upon motion of Drs. Black and Larson, the secretary was instructed to withhold distribution of these resolutions but to prepare them and have them ready for introduction at the special meeting on February 6.

## THE COUNCIL

January 24, 1965

The Council of the Indiana State Medical Association convened for its January meeting at 10:00 a.m., Sunday, January 24, 1965, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. Eugene S. Rifner, the chairman, presiding.

Roll call showed the following present:

**Councilors:**

First District—P. J. V. Corcoran, Evansville
Second District—E. T. Edwards, Vincennes
Third District—Donald M. Kerr, Bedford
E. L. Wallace, New Albany, alternate
Fourth District—Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—V. Earle Wiseman, Greencastle
Sixth District—William R. Tindall, Shelbyville
Frank H. Green, Rushville, alternate (also AMA alternate delegate)
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Paul W. Sparks, Winchester, alternate
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Whiting
Lee Trachtenberg, Hammond, alternate
Eleventh District—Eugene S. Rifner, Van Buren
Lowell J. Hillis, Logansport, alternate
Twelfth District—Milton F. Popp, Fort Wayne
William R. Clark, Fort Wayne, alternate
Thirteenth District—Jene R. Bennett, South Bend

**Officers:**

Joe M. Black, Seymour, president
Kenneth O. Neumann, Lafayette, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer

**Journal:**

Frank B. Ramsey, Indianapolis, editor

**Executive Committee:**

Ralph V. Everly, Indianapolis, chairman
G. O. Larson, LaPorte, member

**Guests:**

Harold C. Ochsner, Indianapolis, AMA delegate
E. S. Jones, Hammond, AMA delegate
John M. Paris, New Albany, AMA alternate delegate
James H. Gosman, Indianapolis, AMA alternate delegate
Robert M. Brown, Marion, AMA alternate delegate
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Student Loan Committee
D. S. Megenhardt, Indianapolis, Professional Advisory Committee, Blue Cross
Lloyd Banks, Indianapolis, Enrollment Director, Blue Shield
Carl P. Huber, Indianapolis, chairman, Maternal Mortality Study Committee
Verne K. Harvey, Jr., Indianapolis, Maternal Mortality Study Committee
Dwight W. Schuster, Indianapolis, chairman, Commission on Legislation

**Staff:**

Ralph Hamill, attorney
Howard Grindstaff, field secretary
K. W. Bush, administrative assistant
J. A. Waggener, executive secretary

**On motion of Drs. Popp and Steen, minutes of the meetings held October 12 and 14, 1964, were accepted as printed in the December, 1964 *Journal*.**

### Reports of Councilors

District meetings were reported scheduled as follows during 1965:

First District—Evansville, May 20, 1965 (tentative)
Second District—Sullivan, June 10, 1965
Third District—Dubois County, ———, 1965
Fourth District—North Vernon, May 19, 1965
Fifth District—Terre Haute, May 7, 1965
Sixth District—Greenfield, May 5, 1965
Seventh District—Indianapolis, May 5, 1965 (tentative)
Eighth District—Muncie, June 2, 1965
Ninth District—Frankfort, May 20, 1965
Tenth District—Gary, May 12, 1965
Eleventh District—Peru, September 15, 1965
Twelfth District—Fort Wayne, May 19, 1965
Thirteenth District— _____

### Reports of Officers

DR. JOE M. BLACK, president: Your president has been attending all of his social obligations with the help of his wife and has been very graciously received. I have had the opportunity to visit some of the other professions, and also some of our districts. I have been meeting about every Wednesday for the past four weeks on medical education and licensure, basically licensure in Indiana. This is one of the many problems that are facing us immediately. We should take a stand some place on where we want to be on medical

licensure. And I'm hoping that the Council and the proper commission can give me some philosophy to follow before too long.

Legislative problems are many. As you no doubt know, the AMA is going to meet February 6 and 7, and we hope our delegates and alternates will be there and express our thoughts for us. As for the state legislature, there are a few very pertinent bills with regard to the profession. Again, licensure is one of the problems that is being discussed in the House, also the psychologist-psychiatrist problem, which I hope can be resolved between the psychiatrists and the psychologists.

Another thing to which we should give some thought is where we stand on the medical school. I think each of you should read parts of the Booz, Allen and Hamilton report and get a little of your own personal philosophy involved in this. First of all, I think the first tenet we have to accept is that we will stand for only the best education available for medicine in Indiana, first and foremost. I think that there ought to be bills introduced in the legislature in regard to other areas of medical education. We need to work on the fact that this is really the responsibility of both the physicians and the hospitals of the state. We should also do something about postgraduate education—work out some way to keep our men at home. This is something that I wish you would think about and study and give me your thoughts. Thank you.

DR. DON WOOD commented on the activities of the Indiana State Medical Association delegation at the AMA interim session in Miami, saying that from the standpoint of public relations the state association had gained a great deal. He thanked the Indiana delegation for their loyal support in his campaign for the office of AMA president-elect.

As a member of the Council on Legislative Activities of the AMA, Dr. Wood then discussed in detail the Kerr-Mills bill, in view of the special meeting of the AMA House of Delegates which will be held in Chicago on February 6 and 7. Two resolutions on this subject had been presented to the councilors for their consideration prior to the Council meeting. Following lengthy discussion of both resolutions by members of the Council, the AMA delegates and AMA alternate delegates, **Resolution No. 1 was adopted on motion of Drs. Donato and Corcoran,** and **on motion of Drs. Donato and Taylor, Resolution No. 2 was adopted.** These resolutions read as follows:

RESOLUTION NO. 1

"WHEREAS, the Indiana State Medical Association wholeheartedly supports the American Medical Association's principles related to tax-supported health care as being sound, and

"WHEREAS, the association continues to be in favor of providing health care for those in financial need at the time of their need, to the fullest extent of their need, regardless of age, and

"WHEREAS, the association believes that health care for those in need may be provided best through federal and state governments cooperating and using general revenue funds, and

"WHEREAS, the association further believes that unmet needs can be resolved through existing laws, although existing programs need adjustment,

"THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association seek such adjustments which would include (1) administration by health agencies instead of welfare agencies; (2) liberalization of eligibility requirements, including that of age, and (3) simplified certification procedures through elimination of welfare investigations."

RESOLUTION NO. 2

"WHEREAS, the Indiana State Medical Association has opposed wage-tax supported health care provided in H. R. 1 and S. 1, for the following reasons, among others:

"(1) The tax proposal is not sufficient to support the services to be provided.

"(2) The inevitable increase in wage-tax to provide more services for all age groups would require an excessive wage-tax and an expenditure equal to one-third of the federal budget.

"(3) The emphasis on the provision of health care in high-cost specialized shelter (i. e. hospitals) in order to receive authorized medical services will unnecessarily increase expenditures and further aggravate the overcrowding and costly over-utilization of hospitals.

"(4) H. R. 1 and S. 1 do not provide a sufficient number of hospital and nursing home days of care for those in need with catastrophic illness.

"THEREFORE, BE IT RESOLVED, that the Indiana State Medical Association urges that if and when, in the opinion of the Indiana State Medical Association, passage of such legislation seems inevitable, the association make every effort to see that, (1) support of medical services provided by physicians are excluded from H. R. 1 and S. 1, and (2), that services of physicians for those in need may be provided in any type of shelter appropriate to the need of the individual through the Kerr-Mills program, supported by general revenue state and federal funds, and

"BE IT FURTHER RESOLVED, that the Indiana State Medical Association make a similar effort to see that wage-tax funds in the King-Anderson bills designated for provision of diagnostic services by physicians (i.e. radiologists and pathologists), which would amount to a huge monetary expenditure, be applied to more adequate nursing home care and special shelter services in the home."

**On motion of Drs. Donato and Shields, the Council approved sending copies of these resolutions to the AMA delegates of all 50 states.**

*Survey of members.* **Drs. Edwards and Corcoran moved that a survey be made of members of the Indiana State Medical Association to obtain their views on the AMA method of achieving the goal of feasible federal-state medical services to include:**

(a) the question of an AMA Public Education

Program through national advertising versus the less publicized action by an AMA Task Force using the doctors' influence on congressmen and the administration to obtain the objectives as outlined in the two Marion county resolutions just adopted by the Council.

(b) to obtain the attitudes of the membership on Social Security; and

(c) any other items that the officers might wish to include in a survey.

This was discussed by Drs. Shields, Popp, Wood, Bibler, Bennett, Donato and Steen. **On a hand vote, the motion was lost.**

DR. OTTIS OLVEY, treasurer, reported that as of January 21, the association was in the black with a checking account balance of $23,888.56, after January operating disbursements had been made and funds for fourth quarter operating expenses and AMERF had been allocated. The investment portfolio remains the same as in the past, with $60,000.00 in the General Fund and $30,000.00 in Medical Defense Fund securities (all U.S. Savings and Treasury bonds).

**On motion of Drs. Popp and Corcoran, the treasurer's report was accepted by consent.**

DR. FRANK B. RAMSEY, editor of *The Journal*, reported that *The Journal* showed a slight profit for the 12 months ending September 30, 1964. In 1963, *The Journal* carried an average of 40 pages of advertising each month. "The first two months just a year ago, we averaged 30; that was down 10 pages at that time. We finished 1964 with an average of 35 pages, and we're starting the first two months this year with an average of 37, which is encouraging.

"I have another encouraging report to make. By contrast, the report of the four largest state society journals in the United States for 1963 has just been published by Pennsylvania. Each of these societies has at least three times as many members as Indiana, one of them six times as many. A state medical journal does better when the membership is large; it's the small circulation journals that have the most trouble. In 1963, California was $20,000.00 behind on their journal, Illinois $22,000.00, New York $150,000.00, and Pennsylvania $28,000.00. That was the year we were only $2,500.00 short."

Dr. Ramsey called attention to the questionnaire printed in the January issue of *The Journal*, which is accompanied by an appeal to all physicians to fill in the questionnaire and return it to *The Journal* office. This type of questionnaire is being run in each of the 35 journals in the State Medical Journal Advertising Bureau in an attempt to prove to advertisers that doctors are interested in their medical journal. "The more interest that is demonstrated, the more advertising we will sell. I would like to request that each councilor make a personal telephone call to each of the county society presidents in his district and ask that county society president to interest the Woman's Auxiliary in his county to talk to their husbands, call their office girls, and in any way possible encourage the return of as many of these questionnaires as is possible . . . . This sounds like a small item. It actually may make a million dollars worth of difference in the amount of advertising our national bureau will be able to sell this next year."

Dr. Shields suggested that the Woman's Auxiliary be contacted regarding this project. Dr. Ramsey stated that he would get in touch with the auxiliary, also that an editorial would appear in *The Journal* on this matter and the newsletter would make mention of it.

*Delegates to the AMA*: DR. E. S. JONES, chairman of the Indiana delegation, spoke on the actions taken by the AMA House of Delegates at the clinical meeting November 29-December 2, 1964, at Miami. (For complete report, see pages 66 to 73, January, 1965, *Journal.*)

Dr. Jones called attention to the fact that Dr. Lester D. Bibler's term on the AMA Board of Trustees will expire this year and stressed the importance of immediately sending letters in behalf of Dr. Bibler's candidacy to all of the AMA delegates in all of the states. Election will take place at the AMA meeting in New York in June, 1965.

**On motion of Drs. Donato and Edwards, and taken by consent, the Council voted to support Dr. Bibler 100% for re-election to membership on the AMA Board of Trustees.**

Dr. Jones also called attention to the meeting of the AMA Congress on Occupational Health which will be held in conjunction with the annual convention of the Indiana State Medical Association in Indianapolis on October 12, 13 and 14, 1965, saying that it is his hope that this will be the best meeting in the 25-year history of the Congress on Occupational Health. Inasmuch as 90% of industrial medicine is done by the general practitioner, the program has been compiled with this in mind.

DR. LESTER D. BIBLER, AMA trustee, commented on several matters which will be discussed by the AMA House of Delegates at its special meeting in Chicago on February 6 and 7:

(1) *AMA dues increase*, which, Dr. Bibler said, may be necessary, in view of proposed educational and legislative programs of the AMA; and

(2) Resolution No. 20, PROVISION OF MEDICAL CARE, introduced by the California delegation, which reads in part as follows:

"Federal help should be based on provision of monetary assistance for the purchase of health care for those who require it, using the voluntary health insurance principles in effect for other segments of the population rather than direct provision of medical and hospital care. The medical profession will support that which will improve the quality of medical care provided in this country, but must oppose that which threatens the quality of medical care."

The reference committee report reads in part: "Next considered was Resolution No. 20, which urged the association to re-affirm its principles

with respect to providing medical care for those who cannot provide it for themselves. Discussion before the committee and our later deliberations point to the desirability of modifying the resolution . . . ."

## Matters Referred to Council by Executive Committee

DR. RALPH V. EVERLY, chairman, Executive Committee, presented the following matters:

1. *Special meeting of AMA, Chicago, February 6 and 7.* Authorization by the Executive Committee for AMA delegates, alternate delegates and members of the Executive Committee to attend the special AMA House of Delegates meeting in Chicago, February 6 and 7, 1965, was approved by the Council by consent.

2. The budget for the year ending September 30, 1965, was approved on motion of Drs. Popp and Steen.

2. *Remission of state dues.* The Council voted remission of state dues as follows:

*Allen County*—two members, due to retirement from active practice, on motion of Drs. Popp and Bennett.

*Lake County*—three members, due to illness and financial hardship, and two members, due to retirement, on motion of Drs. Steen and Kerr.

*Marion County*—one member because of illness, one member because of absence from the United States in 1965, and two members because of retirement from active practice, on motion of Drs. Donato and Edwards.

*Tippecanoe County*—One member because of illness, on motion of Drs. Neumann and Popp.

## Economic and Organization Matters

1. 1964 *Membership report by districts,* as follows, was presented:

MEMBERSHIP REPORT
INDIANA STATE MEDICAL ASSOCIATION
December 31, 1964

| DISTRICT | Members ISMA | # Delegates 1965 Session | AMA | Gain or Loss over 1963 ISMA | Gain or Loss over 1963 AMA | Removed from ISMA Non-Payment | Deaths | Non-Members Elig. | Non-Members Non-Elig. |
|---|---|---|---|---|---|---|---|---|---|
| **1st District:** | | | | | | | | | |
| Gibson | 15 | 1 | 15 | −1 | −1 | | 1 | | |
| Perry | 11 | 1 | 11 | −1 | −1 | | | | |
| Pike | 4 | 1 | 4 | | | | | | |
| Posey | 10 | 1 | 10 | | | | | | |
| Spencer | 4 | 1 | 3 | −1 | −1 | | | 1 | |
| Vanderburgh | 235 | 5 | 231 | −4 | −4 | | 1 | 8 | |
| Warrick | 7 | 1 | 8 | −2 | −2 | | | 2 | |
| Total | 286 | 11 | 282 | −9 | −9 | | 2 | 11 | |
| **2nd District:** | | | | | | | | | |
| Daviess-Martin | 19 | 2 | 18 | −1 | −1 | 1 | | 1 | |
| Greene | 16 | 1 | 9 | | | | | | |
| Knox | 39 | 1 | 37 | −2 | −2 | | 1 | | |
| Owen-Monroe | 61 | 2 | 59 | −1 | +2 | 3 | 1 | 6 | |
| Sullivan | 15 | 1 | 13 | | | | | | |
| Total | 150 | 7 | 136 | −4 | −1 | 4 | 2 | 7 | |
| **3rd District:** | | | | | | | | | |
| Clark | 41 | 1 | 40 | +3 | +3 | 1 | 1 | 6 | |
| Dubois | 24 | 1 | 21 | +1 | +3 | | 1 | | |
| Floyd | 37 | 1 | 36 | −1 | −1 | 1 | 1 | 1 | |
| Harrison-Crawford | 12 | 2 | 12 | +1 | +1 | | 1 | | |
| Lawrence | 23 | 1 | 21 | −1 | −1 | | | | |
| Orange | 9 | 1 | 9 | | | | | | |
| Scott | 4 | 1 | 3 | | | | | 3 | |
| Washington | 7 | 1 | 7 | −1 | −1 | | | | |
| Total | 157 | 9 | 149 | +2 | +4 | 2 | 4 | 10 | |

| DISTRICT | Members ISMA | # Delegates 1965 Session | AMA | Gain or Loss over 1963 ISMA | Gain or Loss over 1963 AMA | Removed from ISMA Non-Payment | Deaths | Non-Members Elig. | Non-Members Non-Elig. |
|---|---|---|---|---|---|---|---|---|---|
| **4th District:** | | | | | | | | | |
| Bartholomew-Brown | 43 | 2 | 42 | | | | | 1 | |
| Dearborn-Ohio | 20 | 2 | 19 | −2 | −2 | | | 2 | |
| Decatur | 12 | 1 | 10 | | | | | | |
| Jackson-Jennings | 25 | 2 | 22 | | | | 1 | 4 | |
| Jefferson-Switzerland | 29 | 2 | 27 | +4 | +4 | | 2 | 2 | |
| Ripley | 8 | 1 | 7 | −3 | −2 | | | 1 | |
| Total | 137 | 10 | 127 | −1 | − | | 3 | 10 | |
| **5th District:** | | | | | | | | | |
| Clay | 12 | 1 | 12 | −1 | −1 | | | | |
| Parke-Vermillion | 25 | 2 | 25 | −1 | −1 | | 1 | | |
| Putnam | 15 | 1 | 15 | −1 | −1 | | 1 | | |
| Vigo | 119 | 2 | 119 | +1 | +1 | | 2 | | |
| Total | 171 | 6 | 171 | −2 | −2 | | 4 | | |
| **6th District:** | | | | | | | | | |
| Fayette-Franklin | 17 | 2 | 17 | −1 | −1 | | 1 | | |
| Hancock | 20 | 1 | 20 | | | | | | |
| Henry | 40 | 1 | 40 | −2 | −2 | | 1 | 1 | |
| Rush | 15 | 1 | 15 | | | | | 1 | |
| Shelby | 19 | 1 | 19 | | | | | 4 | |
| Wayne-Union | 74 | 2 | 69 | +3 | +2 | 1 | 3 | 2 | |
| Total | 185 | 8 | 180 | − | −1 | 1 | 5 | 8 | |
| **7th District:** | | | | | | | | | |
| Hendricks | 24 | 1 | 24 | +2 | +2 | | 1 | 2 | 1 |
| Johnson | 29 | 1 | 29 | −3 | −3 | | 1 | | |
| Marion | 1067 | 21 | 1063 | | −2 | 3 | 21 | 53 | 2 |
| Morgan | 17 | 1 | 17 | | | | | 4 | |
| Total | 1137 | 24 | 1133 | −1 | −3 | 3 | 23 | 59 | 3 |
| **8th District:** | | | | | | | | | |
| Delaware-Blackford | 116 | 3 | 111 | +1 | +1 | | 1 | 3 | 1 |
| Jay | 16 | 1 | 14 | −1 | −1 | | 1 | 1 | |
| Madison | 96 | 2 | 93 | −4 | −3 | 3 | | 5 | 1 |
| Randolph | 21 | 1 | 19 | −1 | | 1 | | 1 | |
| Total | 249 | 7 | 237 | −5 | −3 | 4 | 2 | 10 | 2 |
| **9th District** | | | | | | | | | |
| Benton | 9 | 1 | 9 | | +1 | | | | |
| Boone | 19 | 1 | 19 | +1 | +1 | | 1 | 1 | |
| Clinton | 18 | 1 | 18 | −2 | −2 | 1 | | | |
| Fountain-Warren | 15 | 2 | 15 | | | | 1 | | |
| Hamilton | 25 | 1 | 18 | −1 | −2 | 2 | 2 | 2 | |

| DISTRICT | Members ISMA | # Delegates 1965 Session | AMA | Gain or Loss over 1963 ISMA | Gain or Loss over 1963 AMA | Removed from ISMA Non-Payment | Deaths | Non-Members Elig. | Non-Members Non-Elig. |
|---|---|---|---|---|---|---|---|---|---|
| **9th District (Contd.)** | | | | | | | | | |
| Montgomery | 27 | 1 | 27 | | | | | 3 | |
| Tippecanoe | 118 | 2 | 116 | +4 | +2 | | 1 | 5 | |
| Tipton | 11 | 1 | 11 | | | | | | |
| White | 12 | 1 | 12 | +1 | +1 | | | | 1 |
| Total | 254 | 11 | 245 | +3 | +1 | 3 | 5 | 11 | 1 |
| **10th District:** | | | | | | | | | |
| Jasper | 7 | 1 | 7 | | | | | | |
| Lake | 419 | 8 | 394 | −7 | −7 | 6 | 2 | 11 | 2 |
| Newton | 5 | 1 | 5 | | | | | | |
| Porter | 32 | 1 | 32 | −1 | −1 | | 2 | 2 | |
| Total | 463 | 11 | 438 | −8 | −8 | 6 | 4 | 13 | 2 |
| **11th District:** | | | | | | | | | |
| Carroll | 9 | 1 | 9 | | | | 1 | | |
| Cass | 38 | 1 | 38 | −1 | +1 | | 2 | 1 | 1 |
| Grant | 71 | 1 | 71 | +3 | +3 | | 2 | 5 | |
| Howard | 67 | 1 | 67 | +3 | +3 | | 2 | 2 | 1 |
| Huntington | 22 | 1 | 21 | −1 | −1 | 1 | 1 | 3 | |
| Miami | 14 | 1 | 14 | +1 | +2 | | 1 | 5 | 1 |
| Wabash | 25 | 1 | 24 | | | | | 1 | 1 |
| Total | 246 | 7 | 244 | +5 | +8 | 1 | 9 | 17 | 4 |
| **12th District:** | | | | | | | | | |
| Adams | 14 | 1 | 14 | −1 | +1 | | | 1 | |
| Allen | 290 | 6 | 284 | +9 | +6 | | 5 | 3 | 2 |
| De Kalb | 20 | 1 | 20 | | | | | 1 | |
| LaGrange | 8 | 1 | 8 | −2 | −2 | | | | |
| Noble | 16 | 1 | 16 | | | | | 1 | |
| Steuben | 13 | 1 | 13 | | | | | 2 | |
| Wells | 37 | 1 | 37 | +4 | +3 | | | 1 | |
| Whitley | 18 | 1 | 18 | −1 | −1 | | 1 | 1 | |
| Total | 416 | 13 | 410 | +11 | +7 | | 6 | 10 | 2 |
| **13th District:** | | | | | | | | | |
| Elkhart | 108 | 2 | 106 | −1 | −1 | 1 | 1 | 7 | |
| Fulton | 12 | 1 | 11 | +1 | | | 1 | | |
| Kosciusko | 19 | 1 | 18 | +2 | +2 | | | 2 | |
| LaPorte | 101 | 2 | 99 | +3 | +3 | | 3 | 1 | |
| Marshall | 26 | 1 | 26 | | +1 | | | | |
| Pulaski | 6 | 1 | 3 | | −2 | | 1 | | |
| St. Joseph | 235 | 5 | 235 | −2 | −2 | | | 10 | 1 |
| Starke | 6 | 1 | 6 | | | | | 1 | |
| Total | 513 | 14 | 504 | +3 | +1 | 1 | 6 | 21 | 1 |
| | | | **SUMMARY** | | | | | | |
| 1st District | 286 | 11 | 282 | −9 | −9 | | 2 | 11 | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 2nd District | 150 | 7 | 136 | −4 | −1 | 4 | 2 | 7 | |
| 3rd District | 157 | 9 | 149 | +2 | +4 | 2 | 4 | 10 | |
| 4th District | 137 | 10 | 127 | −1 | − | | 3 | 10 | |
| 5th District | 171 | 6 | 171 | −2 | −2 | | 4 | | |
| 6th District | 185 | 8 | 180 | − | −1 | 1 | 5 | 8 | |
| 7th District | 1137 | 24 | 1133 | −1 | −3 | 3 | 23 | 59 | 3 |
| 8th District | 249 | 7 | 237 | −5 | −3 | 4 | 2 | 10 | 2 |
| 9th District | 254 | 11 | 245 | +3 | +1 | 3 | 5 | 11 | 1 |
| 10th District | 463 | 11 | 438 | −8 | −8 | 6 | 4 | 13 | 2 |
| 11th District | 246 | 7 | 244 | +5 | +8 | 1 | 9 | 17 | 4 |
| 12th District | 416 | 13 | 410 | +11 | +7 | | 6 | 10 | 2 |
| 13th District | 513 | 14 | 504 | +3 | +1 | 1 | 6 | 21 | 1 |
| Total | 4364* | 138 | 4256 | −6 | −6 | 25 | 75 | 187 | 15 |

*Plus one honorary member, Dr. Dwight Murray, Napa, California, not in this number. Report includes 2 honorary members and 42 full dues paying members who are out of the state.

## New Business

1. *Letter from the Grand Hotel, Mackinac Island,* inviting the Council to consider the Grand Hotel as a possible meeting site, was tabled **on motion of Drs. Edwards and Bennett.**

2. *Drivers' insurance.* Dr. Corcoran discussed the matter of drivers' insurance for persons over 65 and the fact that many physicians are being called upon to underwrite the ability of individuals over 65 to drive a car safely. **On motion of Drs. Corcoran and Edwards, the Council instructed the chairman to refer this matter to the appropriate commission for prompt study and action.** The commission to which this problem is assigned is "to make a thorough study of all facets of this," and specifically as it concerns ophthalmology.

## Reports of Guests

1. DR. A. C. OFFUTT, State Health Commissioner, announced that Dr. Carl Huber, chairman of the Maternal Mortality Study Committee, would discuss the matter of federal grants for maternal and infant care, action on which was deferred until the January Council meeting. At the October Council meeting, Dr. Offutt recommended approval of Indiana's participation in this program.

DR. CARL HUBER explained in detail the maternal and infant care program whereby federal funds would be available through the State Board of Health to communities in which the physicians voted to accept such funds. The program is planned to take care of high risk maternity patients and to make it possible for those who ordinarily would not get adequate prenatal care to receive such care, including hospitalization when necessary.

**Dr. Popp moved that this program be accepted. Motion seconded by Dr. Kerr.** Discussed by Drs. Verne K. Harvey, Jr., Donato, Shields, Offutt and Edwards. Dr. Edwards concluded: "I think this Council has previously gone on record in an enabling legislative manner to provide utilization of specialized grants under the discretion and supervision of the State Board of Health, at the option of the local counties. And since there are some 92 counties in Indiana, we represent individually only a few of those. It probably would be appropriate to approve the motion as stated, and then further study can be made in detail by affected counties, and these counties should be permitted to do what they like. If we vote against the motion, we then prevent any county from utilizing this if they have a need."

**By a hand vote, the motion to accept this program was adopted with three dissenting votes (Drs. Donato, Shields and Tindall.)**

*TB eradication.* Dr. Offutt reported that the final draft of the material on the keeping of a TB register, in the TB eradication program, had been completed and had been referred for final review and action to the medical men on the committee. He asked that the Council encourage the reporting of tuberculosis cases. "There needs to be some encouragement on the part of the state medical association for the reporting by physicians of tuberculosis. The entire program is going to be accented on reporting and on follow-up. The matter of treatment will be handled, I am told, by the state medical association and the subcommittee of the Commission on Public Health."

2. DR. D. S. MEGENHARDT, member of the Professional Advisory Committee of Blue Cross, had no official information to convey to the Council. He expressed appreciation for the fine liaison prevailing between the Board of Directors, the Council and association officers. "I personally feel, and I think the other Board members feel, at this time that our liaison is better this last year than it has been for many years."

3. MR. LLOYD J. BANKS, director of Enrollment Division, Blue Cross-Blue Shield, distributed to members of the Council the annual experience report of the Blue Cross-Blue Shield plan for Indiana physicians and explained the significant highlights of the report. Mr. Banks reported that the experience of the Health Care Plan for the past

year demonstrated a need for an increase in membership fees and the experience of the Health Security Plan justified a membership fee reduction. He recommended that both adjustments be made effective on the anniversary date of the association plan which is April 1, 1965. The Council accepted the report and approved the request in the adjustment of the membership fees for all members through the association plan.

## Matters from Committees and Commissions

1. *Student Loan Committee.* Dr. Bibler, chairman, reported that $20,810.00 is on deposit with the Indiana National Bank to guarantee loans under the new student loan plan. Up to this time 18 loans have been granted, for a total of $11,300.00. The Committee on Student Loan met on January 20, 1965 and loans totaling $5,800.00 were authorized for seven students.

Dr. Bibler also reported that up to this time the AMA Student Loan Fund has provided I.U. students with a total of $472,000.00 in loans.

2. *Grievance Committee case,* concerning charges made by Riley Hospital in which two different amounts were stated for hospital fees was discussed by Dr. Clark. A letter from the assistant dean of I.U. Medical School to the chairman of the Grievance Committee stated that the difference of $300.00 between what the parent was billed and what the insurance company paid "would be credited to a 'Special Benefits' account which would be used to support the expanding resident and intern program."

Dr. Clark explained further that at the I.U. Medical Center there are two categories of patients: (1) private patient, who pays the hospital bill and the attending staff physician, and (2) the staff patient, who pays only the hospital bill, and the resident staff and school faculty are responsible for his care. "Now, it looks as though this child had some surgical procedure and the hospital bill of $887.10 was paid in full. Then the parent was billed for $300.00, apparently for the surgery, and since there was no specific surgeon, this payment was diverted to this fund. Now I'll agree that a bill should have been sent for the surgical procedure in order to claim it, but since it wasn't, I think the parent's obligation quite clearly was $887.10 and that the $300.00 (paid by insurance company) belongs to the patient's father.

Discussed by Drs. Corcoran, Shields, Petrich, Kerr, Edwards, Popp and Steen.

**Dr. Shields moved that inasmuch as this is a matter outside the realm of the state medical association, including the Grievance Committee, the Council had no jurisdiction to act upon it. Motion seconded by several.**

Dr. Bennett said he felt that the Indiana State Medical Association could do nothing but disclaim any responsibility in the matter—that this was a problem for the university and its staff.

Dr. Edwards said he thought that when a patient presented a grievance to the committee that is established to receive such complaints, the patient is entitled to an answer and the committee is obligated to give an answer. "Now, I think that we can state though that the procedure followed by the university certainly is not one that we approve of and we hope that correction will be made so that there are no further grievances like this."

Judge Hamill read Section 4 of Chapter X of the Bylaws regarding the duties of the Grievance Committee: "The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct."

Judge Hamill said that "from a policy point of view, you would want to write a letter to this man that would explain everything, and satisfy him. But as a committee, this Grievance Committee has no jurisdiction on this particular issue."

**Dr. Shields amended his motion to include the section of the Bylaws concerning the duties of the Grievance Committee, as read by Judge Hamill. The amendment to Dr. Shields' motion was accepted by those who seconded the original motion. On voting, the motion, as amended, was carried.**

3. *Council Liaison Committee with I.U. School of Medicine.* (Drs. Black, Neumann, Everly and Rifner). **On motion of Drs. Edwards and Steen, the Council voted to refer, for discussion, the above Grievance Committee case to the Council Liaison Committee with I.U. School of Medicine.**

Dr. Rifner announced that this committee expects to meet as soon as a new dean is chosen.

4. *Council Liaison Committee with Blue Shield.* (Drs. Bennett, Wiseman, Steen and Donato). Dr. Bennett reported that it was announced at the last Blue Shield board meeting that Mr. R. S. Saylor, executive vice-president, will retire as of December 31, 1965, and that Mr. Richard Kilbourne will succeed him.

Dr. Donato suggested, inasmuch as the Council Liaison Committee members have no voice in the Blue Shield meetings—they are merely observers—that just one member attend each meeting. Since Blue Shield has just four meetings a year, each of the four liaison committee members would have only one meeting a year to attend. **On motion of Dr. Donato, seconded by several, the Council approved this suggestion.**

The Blue Shield program for dental coverage was discussed. Following discussion by many, Dr. Edwards recalled for the information of the Council that during his last term as chairman of the Commission on Medical Economics and Insurance (1963) a resolution was submitted to and approved by the ISMA House of Delegates which urged the writing of such a policy. Also, if deemed necessary, a dentist is to be included on the board. This is to be strictly an indemnity program.

5. *Council Liaison Committee with Blue Cross.* Dr. Taylor, chairman, had no report.

6. *Council Committee of Business Consultants for The Journal.* (Drs. Tindall, Corcoran and Popp.) This committee had no report in addition to that made earlier in the meeting by Dr. Ramsey, editor.

7. *Commission on Legislation.* Dr. Dwight

Schuster, chairman, reported that his commission was meeting every Wednesday, to go over legislative matters. He asked the Council for clarification and direction in terms of policy on several matters:

(1) *Proposed new medical schools in Indiana.* **Dr. Taylor moved that the Council go on record as saying that additional medical schools should be established in Indiana, the location to be determined at a later date. Seconded by Dr. Corcoran.** Motion discussed by many, following which **Dr. Black moved that Dr. Taylor's motion be tabled** and that the Indiana State Medical Association make a study, analyze the Booz, Allen and Hamilton report, and analyze what the I.U. School of Medicine is going to do in the future, and then come up with an evaluation of the problem. "I am reasonably sure that our legislature is going to have a study commission to do this, and I think it is important that we be a part of this study commission. . . . I think we would be better off if we waited and are asked to join a group to study the needs of medical education in the state of Indiana. **I'll so move." Motion seconded by Dr. Donato, put to vote, and carried.**

**Dr. Shields' motion that "the Council reiterate its stand as far as a policy for better medical education is concerned, and if future study indicates a need for a new medical school, the state medical association would be behind it" was lost for want of a second.**

Following further discussion, **Dr. Edwards moved that the Indiana State Medical Association, through the Commission on Legislation and other appropriate commissions, actively participate in the study of medical education needs in Indiana, in conjunction with other interested groups, or with the Legislative Study Commission which might be created.** "The idea here is that we are in on the study and not just approving something someone else has done." **Motion seconded by Dr. Corcoran, put to vote, and carried.**

(2) **Bill introduced in legislature to enable hospitals, non-profit in type, to obtain through the power of eminent domain needed land for expansion.** Dr. Schuster stated that this bill was introduced in conjunction with the expansion program of the Indianapolis Hospital Development Association to enable the association to purchase land at a reasonable cost. Lake county requested the same type of legislation in the last legislature and it was passed. The present bill differs only in that it applies to first class cities.

**Dr. Donato moved that the Council go on record approving the new bill to include class one cities. Motion seconded by Dr. Shields.**

This subject was discussed by Drs. Popp, Steen, Petrich, Donato and Shields. It was the consensus of some of the councilors that the state medical association had no right to voice an opinion in this business and such a law would take away individual rights to own property unless it is detrimental to the public welfare.

**On voting by hand, the above motion was defeated.**

(3) *Medical licensure.* Dr. Schuster presented for discussion and consideration four proposed changes in the Indiana Medical Practice Act:

(a) *Acceptance of National Board examinations.* If a physician has been licensed in another state after taking the National Board examination, he should be entitled to a license by reciprocity in Indiana.

(b) *Changes in foreign graduates' requirements.* A bill now in the legislature proposes waiver of citizenship. This bill, or its provisions, will be dropped if a suitable change can be made for licensing graduates of foreign schools. Dr. Schuster asked for guidance on policy as to the time an individual has to be in the United States and any other elements the Legislative Commission should consider in proposed licensure changes.

(c) *Changes in licensing regulations to facilitate interns coming to Indiana.* Dr. Schuster presented the possible changes that interns would not be licensed but merely registered with the State Board of Medical Registration and that residents would be acceptable on temporary permits with a fee of $10.00.

(d) *Medical Registration Board income and expenditures.* The board's surplus of approximately $64,000.00 per year received for fees goes into the state's general fund. The board could use some of this money for investigators, to enforce the law, but it must operate on what the State Budget Committee allows it.

**Dr. Steen moved that all of the recommendations dealing with medical licensure presented by Dr. Schuster be adopted and promulgated forthwith. Motion seconded by Dr. Corcoran.**

**Following much discussion, Dr. Steen amended his motion to the effect that "the Council should endorse all of the work done by the Board of Medical Registration in attempting to re-evaluate our licensing procedures, and after these matters have been cleared with the board, we should work with the legislators." Amendment seconded.**

Dr. Black said: "We have been working on this thing for about three or four Wednesdays in a row, and I feel that you would be wrong in trying to tell the legislative commission what to do in regard to this legislation. They are interested in this program, and so is the Commission on Medical Education and Licensure, and I think you are over-stepping your bounds and over-stepping all of your knowledge in trying to tell the legislative commission what to do in this instance. I would like a vote of confidence for your legislative group to tell them to use their best judgment on what to do on this program."

**Dr. Steen withdrew his amended motion.**

**On motion of Drs. Petrich and Shields, the Council commended and approved the work of the Commission on Legislation and the Commission on Medical Education and Licensure for their study of licensure procedure and voted to encourage the members of these commissions to continue their study and efforts in this matter.**

## Date for Spring Meeting

**The date of April 4, 1965, was selected for the next meeting of the Council, on motion of Drs. Corcoran and Edwards.**

There being no further business, the meeting was adjourned.

# COMMERCIAL ANNOUNCEMENTS

FOR SALE: Mattern x-ray and fluarascape with table and complete accessaries. Nat latest madel but very serviceable and daes excellent wark. Ideal for office af man in rural practice. Cantact J. M. Kercheval, M.D., 819 S. Third St., Clinton, Ind.

AVAILABLE July 1, 1965, well established practice far internist or general practitianer, gross 60,000 yearly. Cantact James E. Farner, M.D., 301 W. Faurth St., Mishawaka, Ind.

ASSOCIATE desired far twa man general practice in small Indiana tawn 15 miles fram Sauth Bend. Inspectian af our madern facility and personal discussian of this opportunity invited. Reply to Bax Na. 306, The Jaurnal, ISMA, 3935 Narth Meridian St., Indianapolis, Ind.

OUTSTANDING appartunity for physician specializing in internal medicine ta be affiliated with well established graup in large metropolitan center. Five internists practicing in graup. Campensatian excellent and na investment necessary. Reply ta Bax 310, The Journal, ISMA, 3935 N. Meridian St., Indianapalis.

FOR RENT: Bungalaw affice to share with dentist in S.E. Fart Wayne residential area. Four raams designed far physician; affice area and receptian raam. Available March, 1964. Call 744-3411.

GENERAL Practice office far sale; five raams, air conditianed, recards included, excellent lacatian near three haspitals and clase ta excellent residential area; large parking lot. Leaving in July to specialize. Contact: Michael Truman, M.D., Hamiltan, Ohia — 89-54541.

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Charges for commercial announcements are:

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DEADLINE: Fifth day of month PRECEDING month of issue. (The Journal is in press approximately one month.)

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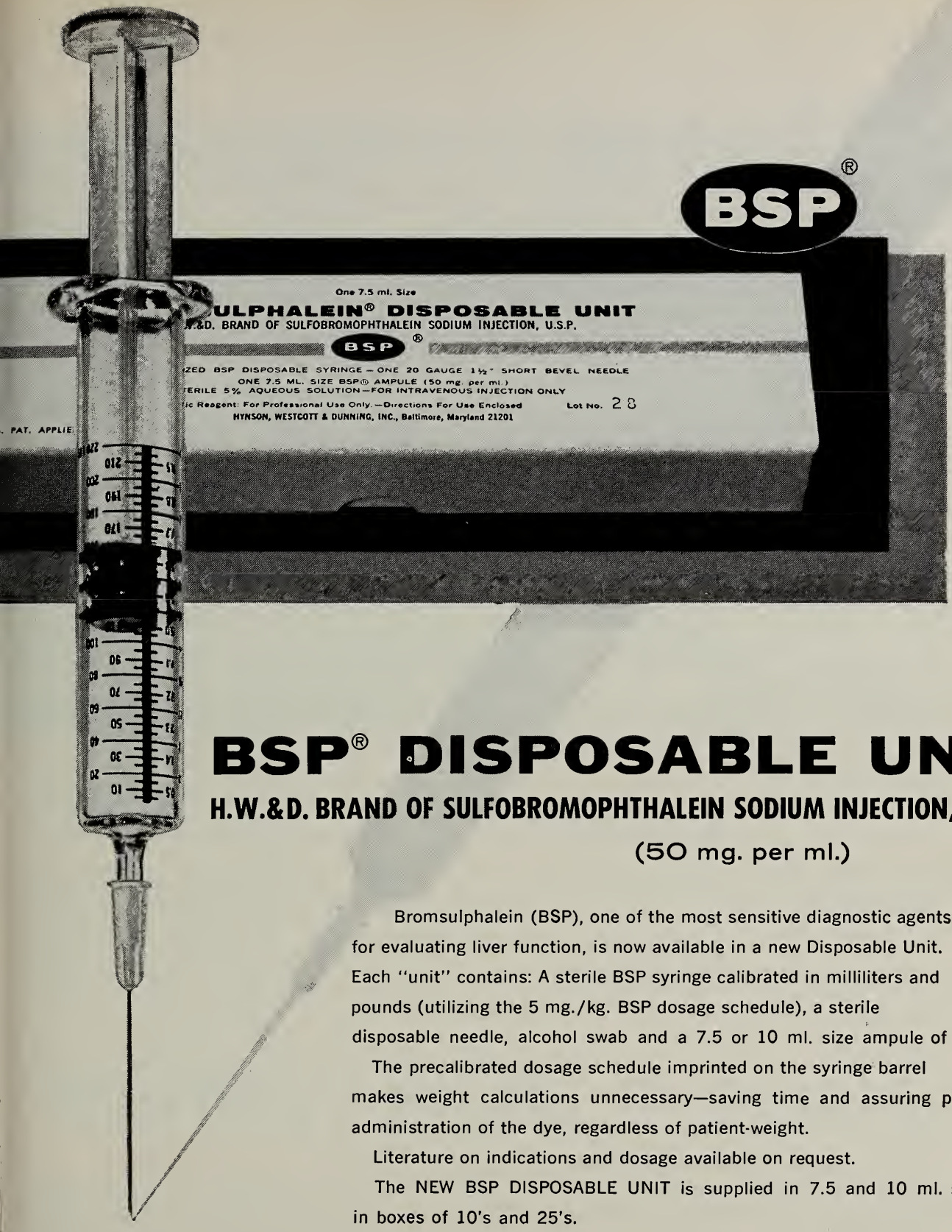
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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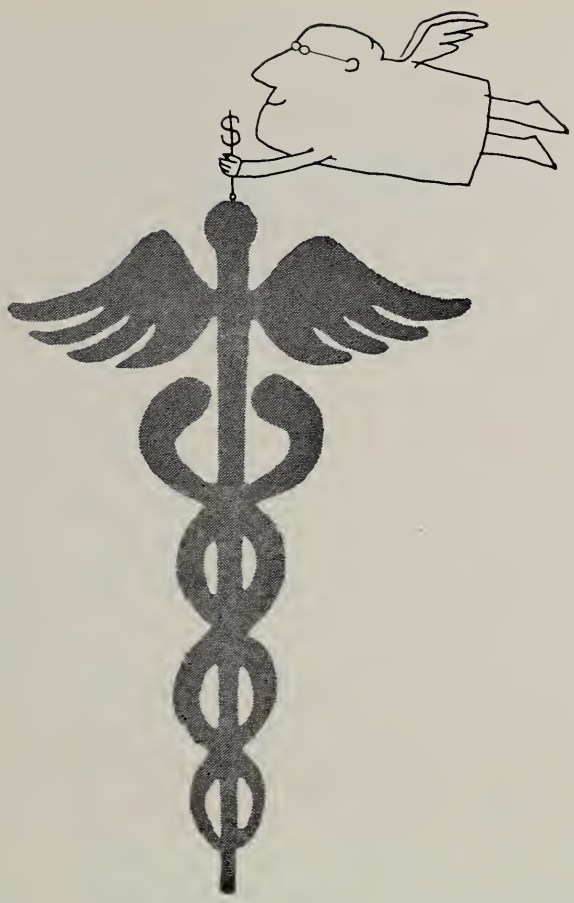
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**BRIEF SUMMARY**

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PRECAUTION: Reduction in dosage of Arthralgen-PR given over a long period should be gradual, never abrupt.

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Arthralgen-PR is generally contraindicated in patients with uremia and viral infections, including poliomyelitis, vaccinia, ocular herpes simplex, and fungus infections of the eye. It is also contraindicated in patients with chicken pox or susceptible persons exposed to it.

SUPPLY: Arthralgen (white, scored) and Arthralgen-PR (yellow, scored) tablets are available in bottles of 100 and 500.

REF: 1. Boreus & Sandberg, ACTA. PHYSIOL. SCAND., 28:266, 1953. 2. Cohen, et al.: J.A.M.A., 165:225, 1957.




This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

The American Medical Association supports a five-year extension of the Vaccination Assistance Act.

Dr. James Z. Appel, Lancaster, Pa., president-elect of the AMA, and Dr. Robert C. Long, Louisville, Ky., a member of the AMA board of trustees, presented the AMA's position on the vaccination program and three other health care bills at a hearing of the house commerce committee.

"Medicine, on the national, state, county and community levels, has consistently worked to bring to its patients the benefit of advances in medical research and development," Dr. Appel said. The physicians of America and the Public Health Service have long been partners in the fight against disease and in the campaign to eradicate contagious disease wherever it is found.

"The Vaccination Assistance Act of 1962 was enacted (with AMA support) in recognition of the fact that there existed all over the country pockets of people, particularly children, who were not utilizing, or who did not have available to them, vaccines for the prevention of poliomyelitis, diphtheria, whooping cough and tetanus. The act authorizes grants to the states to enable them to engage in a concentrated campaign to provide immunization to people in these pockets. We believe that substantial progress has been made and we recommended the program's continuation. . . .

"Medical research has (since 1962) provided an effective vaccine against measles. An intensive vaccination program directed at preschool age children can dramatically lessen the incidence of the disease and reduce or eliminate the serious residual effects which are sometimes attendant with the disease. We therefore believe that it is most fitting that in extending the Vaccination Act, H.R. 2986 include measles in the authorized vaccination programs."

The AMA also supported a five-year extension of the federal grant program for family health services for migratory workers.

The AMA opposed legislation that would authorize the Public Health Service to construct and operate regional or national research facilities. Dr. Appel said:

"We fail to see how research can be classified as 'regional' or 'national' or 'local.' Research in cancer which may be carried on in a medical school research facility in a midwestern city is as 'national' in character as if it were carried on in a city on the west coast. Research in heart disease, or in any of the many areas of interest to medical science, has no geographic bounds. . . .

"We believe that the country will best be served through the utilization

of the experience and knowledge of institutions which are currently engaged in medical research. Their record is a good one. We see no reason for beginning a new program which would require many months or years and large sums of money, and which would compete for scarce skilled research manpower. . . ."

Dr. Long outlined the AMA's opposition to use of federal matching funds for initial staffing of community health centers.

"We believe that once the center has been constructed, the community should assume the remaining responsibility," Dr. Long said.

"The providing of medical care is essentially a community affair. The federal government's participation in a matching grant program stimulates the start of the local program and helps the state or community overcome the initial heavy financial burden. Most often, the problem initially facing a community is the one-time large construction-cost expenditure. Assistance here, by way of federal matching grants, is, in our opinion, appropriate. The funds for staffing, however, should remain the sole responsibility of the local community. There does not appear to be any justification for federal participation in financing this type of expense, nor is it likely to phase out, as stated in the bill, once the federal government has assumed this responsibility. If the community cannot, or will not, support the program from its beginning years, it is not likely to do so later."

As for legislation that would authorize federal mortgage insurance and loans to help finance the cost of constructing and equipping facilities for the group practice of medicine and dentistry, the AMA said:

"We do not believe that this proposal for federal subsidy can be justified. Special preference to physicians who will be eligible for the loan or mortgage insurance under this measure can only be supported on the basis that adequate sources of financing do not exist through banks, insurance companies and other agencies. We know of no such evidence. It has not been demonstrated that this legislation is required to expand currently available public or private funds to finance or insure the construction and equipping of medical or dental groups. . . .

"The bill specifies that the surgeon general shall give preference to, in effect, closed panel prepaid group health plans. This priority discriminates against other physicians in private practice either as solo practitioners or in partnerships or groups."

## REGIONAL MEDICAL COMPLEXES PLAN NEEDS STUDY

The AMA also has emphasized to Congress that the Johnson Administration's plan for a network of regional medical complexes could have "significant impact" upon the practice of medicine in the United States.

Dr. F. J. L. Blasingame, executive vice president of the AMA, advised Sen. Lister Hill (D., Ala.), chairman of the senate labor and public welfare committee, that the AMA could not testify on short notice on S. 596, the "Heart Disease, Cancer and Stroke Amendments of 1965."

Despite the far-reaching potentialities of the legislation, Hill unexpectedly called two days of hearings on short notice in February.

Blasingame said in a letter to Hill:

"We regret that we found it necessary to inform you that we could not present the association's views at that time. Because of the short notice given of the hearings, it was not possible to accord this important legislation the proper measure of consideration which it warrants.

"We are sure that this committee must appreciate the tremendous significance of the legislation before it. The purposes of it, namely to assist in combating heart disease, cancer and stroke, and other major diseases, are most laudatory. The eradication or control of such diseases, as well as of all other medical afflictions of man, has been and continues to be, an active concern and goal of medicine.

"We deem it imperative that S. 596 be given consideration commensurate with the significant impact which it could have upon the course of medicine and upon the health needs of our citizens.

"The association has initiated steps within its organization to give to S. 596 a most careful analysis of its intent and the manner in which it is sought to be implemented and achieved. We cannot urge too strongly to this committee that this legislation raises considerations with far-reaching ramifications and with a potential of far-reaching effects upon the nation's health needs. The course to be charted must represent the most judicious employment of the nation's medical resources."

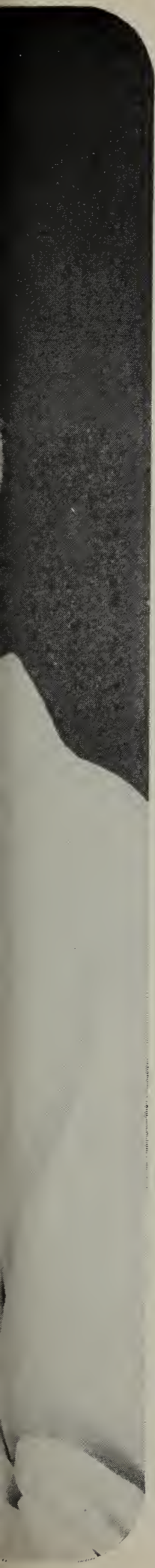
The bill would amend the Public Health Service Act by adding a new title which would authorize the appropriation of $50 million for fiscal 1966, and such sums as may be necessary for the next four years, to be used as grants to assist public or private nonprofit universities, medical schools, research institutions and other public or nonprofit institutions and agencies in the planning, establishing and operating of regional medical complexes for research and training and for demonstrations of patient care in the fields of heart disease, cancer, stroke and other major diseases.

The administration has refused to give Congress the total amount of planned expenditures on the program, if it is approved by Congress, over the five-year period. But administration sources estimated $1.2 billion when the legislation was introduced.

## DR. LUTHER L. TERRY REAPPOINTED SURGEON GENERAL

President Johnson has named Dr. Luther L. Terry for another four-year term as surgeon general of the Public Health Service.

A 53-year-old native of Alabama, Terry has been with the PHS since 1942 when he became assistant director of the National Heart Institute. The late President Kennedy appointed him surgeon general in 1960. ◄



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**Side effects:** Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Usual adult dosage:** One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

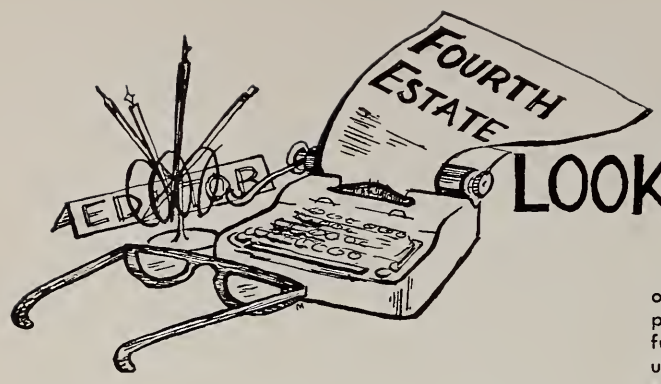
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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Preventable Problem

From Central State Hospital in Indianapolis has come some fascinating new information regarding the relationship between measles and juvenile delinquency.

Dr. Paul Williams of that hospital has been studying the aftereffects of measles in children over a long period of time and has concluded that measles leave massive personality scars on a certain percentage of its youthful victims. And, he found, these emotional and physical scars range in severity from changing an otherwise docile child into a problem child to actual mental retardation.

Happily, new vaccines against this disease are now available and inexpensive. They are certainly in reach of any parents of young children, one way or another. And no child these days should be allowed to grow up without protection against this potentially crippling disease.

Dr. Williams believes that up to an astonishing 30% of juvenile delinquency could be eradicated by the elimination of measles.

Any effort toward reducing our growing problem of juvenile crime is a worthwhile one which should receive wide community support.

A massive attack on this childhood disease certainly ought to become an immediate and easily realized goal for American medicine.—*Indianapolis Star*, Feb. 24, 1965.

## New Medical School Dean

For approximately a year Indiana University has been conducting a nationwide search to find a man qualified to be dean of its Medical School.

The position was left vacant last February [1964] by the death of Dr. John D. VanNuys, who as dean for 17 years had continued to improve the quality of the school, one of the fine medical colleges of the nation. Dr. John I. Nurnberger, who has served as acting dean since Dr. VanNuys' death, has done an excellent job.

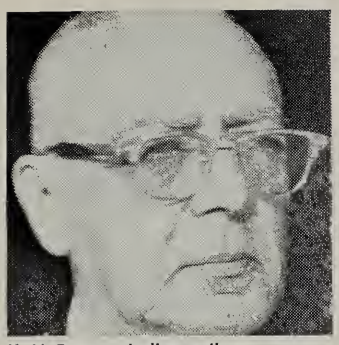
It is a tribute to the caliber of the personnel at the Medical School that the search for a new permanent dean was fulfilled here at home on the I.U. Medical School campus.

The man who will take over the deanship March 1 is Dr. Glenn W. Irwin Jr., professor of medicine, a native of Roachdale and holder of B.S. and M.D. degrees from Indiana University. I.U. President Elvis J. Stahr has expressed his gratification at finding a prospective dean on the campus.

By all accounts, Dr. Irwin is eminently fitted for his job. He is known as an outstanding teacher and, judging from his activities in medical organizations, is held in high respect by fellow members of his profession.

Dr. Irwin faces a challenging task of educating future doctors in an era of constant demand for quantity as well as quality in the finished product. It is expected he will maintain and enhance the reputation of the school.

We wish him every success. His background and record indicate he will justify the faith of the university administration. —*Indianapolis News*, Feb. 24, 1965. ◄



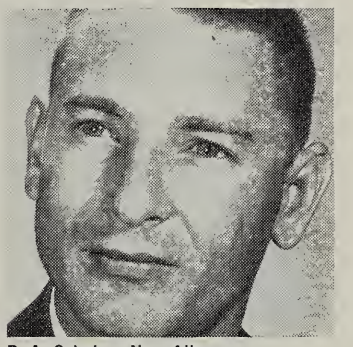
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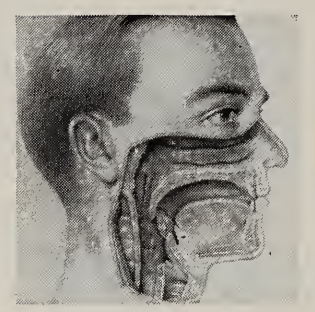
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Supervised by THE COUNCIL

Volume 58 — April 1965 — Number 4

# A Six-Year History of an Infection Committee*

JOHN H. IVY, M.D.†
*Elkhart*

IN AUGUST, 1958, the Joint Commission on Accreditation of Hospitals[1] and the American Hospital Association[2] recommended that all hospitals should establish Infection Committees, charged with the responsibility of investigating, controlling and preventing infections within hospitals. This is a report on the experience of such a committee in the Elkhart General Hospital.

The Elkhart General Hospital is the only hospital in a community of about 40,000, serving an area which includes a population of about 75,000. The hospital contains 197 beds and 26 bassinets. The medical staff is open to all licensed physicians and is composed of both general practitioners and specialists. There are no interns or residents. In addition to the regular nursing staff, there are student nurses from the Goshen College School of Nursing.

## Methods

In order to provide adequate representation of the various groups involved, the Infection Committee was composed of members from the Departments of Surgery, Medicine, Obstetrics and Gynecology, Pediatrics, Clinical Pathology, Administration and Nursing. The responsibilities and functions of the various groups involved were defined in the following policies:

1) The hospital administrator should be responsible for:
   a) Maintaining persistent surveillance of all infections.
   b) Carrying out the procedures jointly agreed upon by the Infection Committee, administrator and nursing staff.
2) The medical staff should maintain a permanent committee for the purpose of advising the administrator on the best methods of controlling infections.
3) The nursing department should be primarily responsible for reporting all infections in patients and hospital personnel.
4) The clinical pathologic department should report on all pathologic organisms cultured in their laboratory.

When the Infection Committee started to function in September of 1958, there was no apparent problem with infections in the hospital. The medical staff and the hospital administration had already established a working system of aseptic technic, isolation and sanitation. It was decided, therefore, to collect data before making changes in the prevailing technic. It required only a few months of observation, however, before the need for modification of the current technics became evident.

By May of 1959, it was decided to use

* Presented in part at The Thirteenth District Meeting, Indiana State Medical Association, Sept. 18, 1963.

† From the Elkhart Clinic, Elkhart.

"The Guide for the Prevention and Control of Infections in Hospitals" by the New York State Department of Health and the American Public Health Association, 1957, as the guide for the Elkhart General Hospital. This was continuously supplemented and the resulting information was brought together in one volume, "Manual on Control of Infections and Isolation Procedures" in January, 1963, by Mrs. Rusche R. Schutt, R.N., Director of Nursing Service, Elkhart General Hospital. This manual spells out the rules and methods for carrying out clean and aseptic technics, the isolation and care of infected patients and the control and treatment of infected hospital personnel.

Clean and aseptic technic has been detailed in many publications. In reviewing these technics, it was discovered that a deficiency existed in the method for changing surgical dressings. Therefore, in January of 1959, an improved system was inaugurated in which individual dressing trays were used for all contaminated wounds. The dressing cart was used only for dressing clean wounds. Changes were also instituted in the operating room area to reduce the traffic. The air conditioning in the operating rooms was not ideal because all of the air conditioning units had to be working to prevent re-circulation of air between the surgical rooms. However, it was found to be too costly to change the entire system.

The proper use of masks proved to be a controversial subject, but was resolved. It was recommended that masks worn during surgical procedures be changed every 30 minutes. Anesthetic masks were washed with G-11 soap after each use. Outside of surgery, masks were not generally recommended, except when attending a patient with a highly communicable disease such as chickenpox, measles, mumps, smallpox and active pulmonary tuberculosis.[3] As a matter of actual practice, masks were available outside the room of each patient in isolation and most doctors, nurses and employees used them.

Some members of the Infection Committee feel that a properly used mask might reduce the chances of a susceptible person contracting a staphylococcal nasopharyngeal infection. Masks were not worn routinely by the nurses and other personnel working in the nursery. Several studies have demonstrated that the wearing of masks by nursery personnel does not prevent the spread of staphylococcal organisms from newborn to newborn.[4,5] Because of their contact with infected patients, physicians, however, were required to wear masks in the nursery.

### Criteria for Isolation

In general, patients with an infection or a suspected infection were isolated. Exceptions to this rule were patients with urinary tract infections, the common cold and suspected viral pneumonia. When routine cultures from the vagina, urinary tract, stool and the upper respiratory tract demonstrated a coagulase positive Staphylococcus aureus, the patient was not isolated unless there were clinical signs of infection. A patient, once isolated, was not removed from isolation until the lesion was entirely healed and/or a repeat culture showed no coagulase positive Staphylococcus aureus. Following these rules, 7,120 patient days were spent in isolation from August, 1961 to August, 1964. This was an average of 6.5 patients in isolation every day.

An attempt was always made to isolate infected patients in private rooms with adequate bath facilities. This restriction was frequently resented and misunderstood by the patient. The attending physician was urged to fully explain the situation and a form letter was prepared to assist the nurse in instructing the patient in the isolation procedure. A form letter was also prepared for visitors to explain the need for isolation and the required procedures. Despite attempts to make isolation as acceptable as possible, emotional disturbances were not uncommon and several patients developed hallucinations.

Because of the lack of adequate space, isolation in private rooms was frequently not possible and cubicle isolation had to be resorted to. Cubicle isolation was carried out in two to four bed rooms and in the hall when the hospital was crowded. This was obviously a compromise and its efficacy was frequently questioned. It was felt, however, that cubicle isolation did reduce transmission of organisms by direct contact and

maintained an awareness of the problem of infection. It did, however, make the other patients in the room uneasy about becoming contaminated; it also discouraged the nurses who felt frustrated in their attempts to do a good job.

Personnel with active infections were restricted from all areas of the hospital and were not permitted to return to duty until the infection had cleared. An infection in a student nurse constituted a serious problem in arranging for her training in the hospital. Substitutes had to be obtained for infected nurses, nurses aides and other hospital employees. Substitutes were sometimes difficult to find, but during the period of this study, the nursing department always managed.

### Recognition of Infection and Culture Records

Routine nasal cultures were required only of personnel starting to work in the nursery. Nasal cultures were also obtained from all personnel, medical and non-medical, who worked in an area of the hospital where an outbreak of hospital-acquired infections was occurring. Personnel whose cultures did not grow the phage type causing the current outbreak, or type 80, 81, were permitted to work without treatment. Asymptomatic carriers meeting these criteria were not restricted from work unless transmission to patients could be demonstrated.

Personnel whose cultures grew the phage type causing the outbreak, or 80, 81, were restricted from work until adequately treated and nasal cultures became negative. The use of Neosporin lotion inside the nostrils and on the skin around the nose, a daily bath with pHisohex skin cleanser and the use of hexachlorophene talcum powder 0.3% on the body after the bath were recommended. Care by the personal physician was also urged and systemic antibiotics were frequently prescribed. Personnel were permitted to return to work after five days of treatment, provided their cultures were negative and remained negative during the following three weeks of treatment.

Compliance with these rules was not uniform and caused some resentment. It was easier to enforce these rules among the hospital employees, including the nurses, than among the physicians. Infected physicians generally accepted treatment and wore masks, but frequently continued to see patients in the hospital. Exclusion from the nursery and the surgical suites was especially emphasized and was generally complied with. Although these exceptions are not desirable, the fact that physicians are in contact with the patients for much shorter intervals than are nurses was believed to reduce considerably the chances of an infected physician contaminating a patient.

The stimulus for maintaining and improving these methods of preventing and controlling infections came from the study of all cultures obtained in the hospital. Basic to such a study is the recognition of an infection and the request for a culture. This was made the responsibility of the nursing department because they have the most intimate and prolonged contact with the patient. The nurses were instructed to advise the attending physician of any infection observed or suspected. In actual practice, the attending physician was aware of the infection and took all the necessary steps to identify the organism and isolate the patient. If a culture was not obtained by the physician, the nursing department was instructed to seek the advice of the chairman of the Infection Committee and the pathologist.

The clinical pathologic laboratory kept records of all cultures obtained. The actual culture of staphylococcal organisms was kept for two months so that phage typing could be carried out for the purpose of investigating an outbreak. The laboratory reported to the Infection Committee:

1) All coagulase positive Staphylococcus aureus,
2) All group A hemolytic streptococci, and
3) All cultures obtained from traumatic wounds, postoperative wounds, pustules, purulent discharges and other obviously infected sites.

The report was assembled and submitted once a month. It contained the date that the culture was obtained, the patient's name, the patient's room number, the attending physician, the site from which the

culture was obtained and the organism cultured. Penicillin sensitivity was indicated on all staphylococcic organisms cultured and the phage type, when known. In addition, a cross was placed before the patient's name when the culture was obtained more than 48 hours after admission to the hospital.

The hospital record of all patients whose cultures were obtained after being in the hospital for more than 48 hours was scrutinized for the possibility of a hospital-acquired infection. It was assumed that organisms cultured within 48 hours of admission were probably brought into the hospital.

The Infection Committee determined whether or not an infection was acquired in the hospital. This determination was made about one month after the organism had been cultured. It was based upon the condition of the patient at the time of admission, the patient's course in the hospital and the nature of the infection cultured. This was not an easy task in many cases. Although never carried out, it was suggested that a questionable category be established for cases such as burns and lacerations where the source of infection was difficult to ascertain.

## Results

The overall results of the first full six years of the surveillance by the Infection Committee are outlined in Table I. The percentages were obtained by dividing the number of infections by the number of admissions, major surgical procedures or new births. No attempt was made to determine whether the cultures were all caused by sepsis or whether they may have represented colonization only. The Infection Committee directed its attention primarily toward the hospital-acquired infections. As a matter of deliberate policy, only those infections that resulted from surgical incisions were attributed to the surgery; burns, decubitus ulcers and other infections removed from the site of the incision were not. Even with these restrictions, surgically-acquired infections made up about 50% of all the hospital-acquired infections. If a pathogenic organism was cultured from a newborn, it was considered to be a hospital-acquired infection only if a lesion or purulent discharge was present.

It is possible that some infections were missed. In the Veterans Administration study[6], the frequency of postoperative infections varied markedly. It was only one percent with routine reporting, but rose to 13% when a special effort was made to detect postoperative infections. An even greater source of omission may have occurred in those infections that became obvious only after the patient had been dismissed from the hospital. The members of the staff were frequently reminded to report such infections to members of the Infection Committee but only a few were reported. Any patient admitted for incision and drainage of an abscess was checked to determine if the infection could have been acquired on a previous hospital admission. A plan to make routine inquiries concerning infections occurring shortly after hospital dismissal was never put into action.

SAMPLE OF REPORT OF POSITIVE CULTURES — MARCH, 1961

| Date | Patient | Room | Doctor | Source | Organism |
|---|---|---|---|---|---|
| 3-9 | S. S. | 218 | Black | Abscess | Staph. aureus |
| 3-19 | J. J. | 225 | Warren | Urine | Staph. aureus * |
| 3-29 + | M. M. | 328 | Larsen | Abdominal incision | Staph. aureus 80,81 * |
| 3-15 | W. W. | 362 | Chavez | Burn | Staph. aureus 77 * |
| 3-6 | A. C. | 442 | Larue | Drain site | Coliform |
| 3-17 | U. A. | 515 | Cabot | Nasopharyngeal | Staph. aureus NT |
| 3-20 + | B. L. | Nursery | Dobro | Pustule | Staph. aureus 53 * Coliform |
| 3-25 + | P. J. | 341 | Scott | Left hip | P. aeruginosa Str. fecalis |

* Penicillin resistant

INCIDENCE OF INFECTIONS IN THE HOSPITAL POPULATION

| | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 |
|---|---|---|---|---|---|---|
| Admissions (Including new births) | 10,334 | 10,538 | 10,577 | 10,303 | 10,916 | 11,168 |
| Major Surgery | 1,736 | 1,788 | 2,002 | 2,061 | 2,018 | 2,800 |
| New Births | 1,750 | 1,772 | 1,736 | 1,657 | 1,810 | 1,701 |
| Total Patients Cultured | 364 | 367 | 323 | 453 | 447 | 558 |
| % of Admissions | 3.5% | 3.5% | 3.1% | 4.4% | 4.1% | 4.5% |
| Hospital-Acquired Infections | 43 | 43 | 37 | 61 | 64 | 56 |
| % of Admissions | 0.42% | 0.41% | 0.35% | 0.59% | 0.59% | 0.50% |
| Surgically-Acquired Infections | 21 | 21 | 19 | 26 | 31 | 26 |
| % of Surgery | 1.2% | 1.2% | 0.94% | 1.26% | 1.53% | 0.93% |
| Nursery-Acquired Infections | 8 | 6 | 5 | 5 | 11 | 5 |
| % of New Births | 0.46% | 0.34% | 0.29% | 0.30% | 0.61% | 0.29% |
| Medically-Acquired Infections | 14 | 16 | 13 | 30 | 22 | 25 |

TABLE I

During 1963 at a time when the nursery was crowded, pustules were discovered on two newborns. A concerned pediatrician made a systematic inquiry about the other infants discharged from the nursery and discovered a total of 12 infants with pustules, probably all caused by Staphylococcus aureus. The reporting of infections occurring after dismissal is considered to be the largest "blind spot" in the present method of surveillance.

A comparison with the infection rates reported in the Veterans Administration[6] and a Canadian study[7] is made in Table II. It is of interest that the proportion of staphylococcal cultures was about 3.5% in all three studies. The proportion of hospital-acquired infections at the Elkhart General Hospital compares very favorably with these two studies. The 224 staphylococcal hospital-acquired infections is less than the total of 304 infections acquired at the Elkhart General Hospital, because 80 infections were caused by organisms other than coagulase positive Staphylococcus aureus. The maximum infection rate was 0.59% in 1962 and 1963. This is considerably below the 1.8% and 1.2% found in the Veterans Administration and the Canadian studies, respectively. The maximum rate of surgically-acquired infections at the Elkhart General Hospital was 1.53% in 1963.

COMPARISON WITH TWO OTHER STUDIES

| | Elkhart General Hospital Study | Veterans Administration Study | Canadian Study |
|---|---|---|---|
| Admissions | 63,836 | 29,817 | 99,597 |
| Total Staphylococcal Cultures | 2,117 | 1,093 | 3,446 |
| % of Admissions | 3.3% | 3.7% | 3.5% |
| Staphylococcal Hospital-Acquired Infections | 224 | | |
| % of Admissions | 0.35% | 1.8% | 1.2% |

TABLE II

This compares favorably with the range of from two to 26% postoperative infections reported in a review of the literature.[7]

Further analysis of the hospital-acquired infections will be found in Table III. On the basis of the age group, it is evident that after the initial high incidence in the newborn, the incidence falls and then rises again after the age of 50. Newborn and especially premature infants are prone to staphylococcal infections.[8] This can be explained in part by the low levels of serum antibody in the premature infant.[9] The extended stay in the nursery of premature infants may also be a contributing factor. The rising incidence in the older age groups is related to the increased frequency of illness and is consistent with the increased frequency of predisposing diseases, such as cancer and diabetes.[7]

Postoperative wound infections make up almost 50% of the various sites of infection. When a hollow viscus or tract is entered, the chances of developing an acquired infection are five times greater than following a clean operative procedure. Urinary tract infections were almost invariably associated with catheterization. Of the nonoperative infections, the respiratory tract and the skin were the most commonly involved. Burns were placed in a separate category and were considered to be a great problem. There seemed to be no effective method of preventing infection in burns until the skin was healed.

Table IV indicates the frequency with which various surgical procedures developed a postoperative infection and the causative organisms. Although Staphylococcus aureus was the cause of the infection in 68% of the cases, there was a significant number of hospital-acquired infections (45) caused by other organisms, tabulated in Table V. The great majority of

HOSPITAL-ACQUIRED INFECTIONS: 1959 THROUGH 1964

| | Age Group | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Newborn | 0 to 10 | 10 to 20 | 20 to 30 | 30 to 40 | 40 to 50 | 50 to 60 | 60 to 70 | 70 to 80 | 80 & up | Total |
| Number of patients with hospital-acquired infections | 40* | 14 | 5 | 21 | 31 | 31 | 47 | 47 | 46 | 22 | 304 |
| SITE OF INFECTION | | | | | | | | | | | |
| A. Postoperative Wounds: | | | | | | | | | | | |
| 1. Clean cases | | 2 | 1 | 2 | | 2 | 3 | 6 | 3 | 5 | 24 |
| 2. Hollow viscus or tract entered | | 2 | 1 | 5 | 16 | 16 | 27 | 26 | 19 | 8 | 120 |
| | | | | | | | | | | | (144) |
| B. Urinary tract | | | | 1 | 4 | 1 | 3 | 3 | 6 | 2 | 20 |
| catheterized | | | | 1 | 4 | 1 | 2 | 3 | 6 | 1 | |
| C. Respiratory tract | 17 | 4 | | 3 | 3 | 4 | 7 | 5 | 10 | 3 | 56 |
| D. Gastrointestinal tract | 2 | 2 | 1 | | | 1 | 1 | 1 | 3 | | 11 |
| E. Skin and eye | 22 | | | 9 | 4 | 6 | 4 | 3 | 3 | 3 | 54 |
| F. Burns | | 3 | 2 | 1 | 4 | 2 | 1 | | | | 13 |
| G. Septicemia | 2 | 1 | | | | | 1 | 2 | 2 | | 8 |
| | | | | | | | | | | | (162) |
| Associated Conditions: | | | | | | | | | | | |
| Diabetes | | | | | | | 4 | 1 | 3 | | 8 |
| Cardiovascular | | | | | | | 4 | 4 | 5 | 1 | 14 |
| Cancer | | 1 | | 1 | 1 | 4 | 7 | 13 | 11 | 6 | 44 |

* 14 newborns were premature

TABLE III

TYPE OF SURGERY COMPLICATED BY HOSPITAL-ACQUIRED INFECTION
(1959 THROUGH 1964)

| | Total Cases | Cases Associated With Coagulase Positive Staphylococcus Aureus | | Cases NOT Associated With Coagulase Positive Staphylococcus Aureus |
|---|---|---|---|---|
| | | Penicillin Sensitive | Penicillin Resistant | |
| Cholecystectomy | 23 | 11 | 7 | 5 |
| Choledochostomy | 1 | | | 1 |
| Colon resection | 9 | 1 | 3 | 5 |
| Abdominal perineal resection | 3 | | 1 | 2 |
| Colostomy | 4 | 1 | 2 | 1 |
| Subtotal gastric resection | 10 | 4 | 3 | 3 |
| Gastroenterostomy | 1 | | 1 | |
| Pyloroplasty | 1 | | | 1 |
| Laparotomy | 11 | 3 | 1 | 7 |
| Appendectomy | 4 | 1 | 3 | |
| Transposition of spleen | 2 | 2 | | |
| Repair of fractured liver | 1 | | 1 | |
| Sphincterotomy of ampula of Vater | 2 | | 2 | |
| Hemorrhoidectomy | 1 | | 1 | |
| Closure of perforated peptic ulcer | 1 | | | 1 |
| Nephrostomy | 3 | 2 | 1 | |
| Nephrectomy | 3 | | 1 | 2 |
| Bladder resection | 2 | 1 | | 1 |
| Urethroplasty | 1 | | | 1 |
| Ureterolithotomy | 2 | | 2 | |
| Cystotomy | 2 | | 1 | 1 |
| Vas ligation | 1 | | 1 | |
| Abdominal hysterectomy | 7 | 4 | | 3 |
| Vaginal hysterectomy | 4 | | | 4 |
| Caesarian section | 2 | 1 | 1 | |
| Dilatation and curettage | 1 | | 1 | |
| Vulvectomy | 1 | 1 | | |
| Oophorectomy | 1 | 1 | | |
| Obturator neurectomy | 1 | 1 | | |
| Pneumonectomy | 4 | | 2 | 2 |
| Thoracotomy | 3 | | 2 | 1 |
| Tracheostomy | 4 | | 4 | |
| Mastectomy | 3 | 2 | | 1 |
| Herniorrhaphy | 4 | 3 | 1 | |
| Open reduction of fracture | 7 | 1 | 5 | 1 |
| Closed reduction of fracture | 1 | 1 | | |
| Removal of broken hip flange | 1 | 1 | | |
| Osteotomy and bone graft | 1 | | | 1 |
| Laminectomy | 1 | 1 | | |
| Leg amputation | 4 | 2 | 1 | 1 |
| Skin graft | 1 | 1 | | |
| Vein stripping | 2 | 1 | 1 | |
| Endarterectomy | 1 | 1 | | |
| Removal of foreign body | 1 | | 1 | |
| Excision of melanoma | 1 | | 1 | |
| TOTALS | 144 | 48 | 51 | 45 |

TABLE IV

ORGANISMS CULTURED WHEN STAPHYLOCOCCUS AUREUS WAS NOT PRESENT
(1959 through 1964)

| Type of Surgery | Coagulase Negative Staph. a | Hemolytic strep. | Non-hemolytic strep. | Strep. viridans | Strep fecalis | "Normal" Intestinal Bacteria P. aeruginosa Proteus Enterococcus E. Coli Clostridium perfringens Alcaligenes fecalis | Gram Negative Bacillus | Gram Positive Bacillus |
|---|---|---|---|---|---|---|---|---|
| Open reduction of hip + | | | | 1 | | 2 | | |
| Laparotomy | 1 | | | 4 | | 8 | 1 | |
| Abdominal hysterectomy | 1 | 3 | | 1 | | 1 | 1 | 1 |
| Vaginal hysterectomy | 1 | | | | 1 | 4 | | |
| Pneumonectomy | | | | | | 3 | | |
| Colon resection | 1 | 1 | 1 | 2 | 1 | 6 | | |
| Abdominal perineal resection | 1 | | | 2 | | 2 | | |
| Mastectomy + | | | | | | 1 | | |
| Subtotal gastric resection | 1 | | | 1 | | 6 | | |
| Cholecystectomy | | 1 | 1 | 1 | 1 | 2 | | |
| Choledochostomy | | 1 | | | | | | |
| Nephrectomy | | 1 | | | | 1 | | |
| Thoracotomy | 1 | | | 1 | | 1 | | |
| Leg amputation + | | | | | | 1 | | |
| Cystotomy | 1 | | | | | | | |
| Pyloroplasty | | | | | | 1 | | |
| Osteotomy & bone graft + | | | | | | 1 | | |
| Urethroplasty | 1 | | | | | | | |
| Closure of perforated peptic ulcer | | | | 1 | | | | |
| Colostomy | | | | | 1 | 1 | | |
| Bladder resection | | | | | | 1 | | |

+ = Hollow viscus or tract not entered.

TABLE V

infections caused by organisms other than Staphylococcus aureus occurred following surgical procedures in which a hollow viscus or tract was entered. All infections were isolated until identification of the organisms was made.

Infections related to "normal" intestinal bacteria were released from isolation upon identification. Infections caused by a hemolytic streptococcus were released within 24 hours after adequate therapy with penicillin was begun. Infections caused by a coagulase positive Staphylococcus aureus were not released until the culture of the wound became negative. The last 13 surgical procedures in Table IV did not enter a hollow viscus or tract. Although the classification of some of these procedures was subject to debate, most of them were considered "clean" cases. Table VI demonstrates that procedures such as chest surgery, gallbladder surgery, gastric surgery, intestinal surgery, laparotomy and kidney surgery are particularly prone to develop postoperative infections.

The nature of the infection and the type of organism causing infections in the nursery are tabulated in Tables VII and VIII. Because of the susceptible nature of newborn infants, all of these infections were watched with particular care. The only death resulting from infection occurred in a premature infant who died of a hemorrhagic pneumonia caused by E. coli and Pseudomonas aeruginosa.

Tables IX and X present the type of organism associated with various non-surgical lesions. The preponderance of coagulase positive Staphylococcus aureus as the cause for these hospital-acquired infections is once again illustrated.

Table XI shows the distribution of pathogenic cultures and hospital-acquired infections in the various sections of the hospital. In the nursery section, those pathogenic organisms that were not acquired infections were considered to represent organisms that had colonized in the infants. On the other sections, those organisms that were not hospital-acquired infections were brought into the hospital by the patient. This table illustrates the fact that the greatest incidence of hospital-acquired infections occurred on the surgical sections. The pediatric section should be noted for the great number of infections brought into the hospital without an apparent spread to other patients. Infections in the hospital personnel could be considered an occupational hazard. However, once infected, the employee can spread the infection widely.

Table XII demonstrates the yearly distribution of all the pathogens cultured. Table XIII shows the yearly distribution of pathogens causing hospital-acquired infections. Acquired infections caused by Staph-

FREQUENCY OF ACQUIRED
INFECTIONS BY TYPE OF SURGERY
(1959 THROUGH 1964)

| Type of Surgery 1959 through 1964 | Total Surgery Performed | Surgical Acquired Infections | |
|---|---|---|---|
| | | Number | Percent |
| Appendectomy | 639 | 4 | 0.63% |
| Caesarian section | 424 | 2 | 0.47 |
| Chest | 85 | 7 | 8.2 |
| Gallbladder | 969 | 24 | 2.48 |
| Gastric | 245 | 12 | 4.90 |
| Intestinal | 474 | 16 | 3.38 |
| Laparotomy | 221 | 11 | 4.98 |
| Kidney | 241 | 8 | 3.31 |
| Hysterectomy | 1,857 | 11 | 0.59 |
| Mastectomy | 170 | 3 | 1.76 |
| Herniorrhaphy | 1,671 | 4 | 0.24 |
| Bone | 838 | 10 | 1.19 |
| All major surgery | 12,405 | 144 | 1.16 |

TABLE VI

TYPE OF INFECTION ACQUIRED IN THE HOSPITAL NURSERY
(1959 Through 1964)

| | Total Cases | Cases Associated With Coagulase Positive Staphylococcus Aureus | | Cases NOT Associated With Coagulase Positive Staphylococcus Aureus |
|---|---|---|---|---|
| | | Penicillin Sensitive | Penicillin Resistant | |
| Upper respiratory infection | 7 | 4 | 2 | 1 |
| Sinusitis | 1 | 1 | | |
| Otitis | 1 | | | 1 |
| Conjunctivitis | 9 | 2 | 2 | 5 |
| Pneumonia | 2 | | 1 | 1 |
| Gastroenteritis | 2 | 1 | | 1 |
| Pustular dermatitis | 10 | 3 | 7 | |
| Infected umbilical cord | 5 | | 1 | 4 |
| Infected spina bifida | 1 | | 1 | |
| Septicemia | 2 | | 1 | 1 |
| TOTAL | 40 | 11 | 15 | 14 |

TABLE VII

ylococcus aureus are as frequent as all other pathogens taken together. Of these pathogens, penicillin resistant organisms make up 50%. This preponderance of staphylococcal infections should not blind one to the fact that other organisms can cause infections. The rising frequency of infections caused by coliform, Pseudomonas aeruginosa, Proteus and streptococcus viridans organisms should be especially noted. Other organisms commonly found in the intestinal tract are also becoming more frequent.

During the first four years of this study, phage typing of staphylococci causing infection in the hospital was done frequently. This resulted in considerable expense, but provided experience that made it possible to change the procedure without any apparent decrease in the information gained from the phage typing. After 1962, phage typing was carried out only when there appeared to be several closely related hospital-acquired in-

ORGANISMS ASSOCIATED WITH NURSERY INFECTIONS WHEN COAGULASE POSITIVE STAPHYLOCOCCUS WAS NOT PRESENT
(1959 THROUGH 1964)

| | Hemolytic Strep. | Strep. Viridans | Coag. Neg. Staph. | Coliform P. Aeruginosa Alcaligenes Fecalis Paracolon Proteus | Pneumo-coccus | Non-Hemolytic Strep. | Gram Positive Bacillus |
|---|---|---|---|---|---|---|---|
| Upper respiratory infection | 1 | | | | | | |
| Pneumonia | | | | 2 | | | |
| Otitis | | | 1 | | | | |
| Conjunctivitis | | 2 | 2 | 2 | 1 | | 1 |
| Gastroenteritis | | | | 1 | | | |
| Infected umbilical cord | 1 | 2 | 2 | 5 | | | |
| Septicemia | | 1 | | | | | |

TABLE VIII

TYPE OF NON-SURGICAL LESION
COMPLICATED BY A HOSPITAL-ACQUIRED INFECTION
(1959 THROUGH 1964)

| | Total Cases | Cases Associated With Coagulase Positive Staphylococcus Aureus | | Cases NOT Associated With Coagulase Positive Staphylococcus Aureus |
|---|---|---|---|---|
| | | Penicillin | | |
| | | Sensitive | Resistant | |
| Urinary tract infection | 20 | 7 | 7 | 6 |
| Gastroenteritis | 8 | 1 | 5 | 2 |
| Stomatitis | 4 | 2 | 2 | |
| Decubitae | 8 | 4 | 3 | 1 |
| Burn | 13 | 2 | 9 | 2 |
| Skin abscess | 23 | 8 | 13 | 2 |
| Pneumonia | 16 | 6 | 5 | 5 |
| Upper respiratory infection | 21 | 13 | 7 | 1 |
| Septicemia | 7 | 2 | 1 | 4 |
| TOTAL | 120 | 45 | 52 | 23 |

TABLE IX

fections. Table XIV shows the yearly distribution of the staphylococcal acquired infections that were phage typed. The decreased frequency of phage typing in 1963 and 1964 is evident. The fact that Staphylococcus aureus 80, 81 was a frequent cause of hospital-acquired infections is consistent with the worldwide distribution of this phage type and its ability to cause outbreaks of hospital infection. [7,10]

### Links in the Infection Chain

Table XV shows the yearly distribution of Staphylococcus aureus 80, 81. Both penicillin sensitive and resistant organisms have been included. The outbreak of acquired infections caused by this organism in the fall of 1959 demonstrated the problem of the care of patients with burns. Two men severely burned simultaneously in an explosion were hospitalized and treated in the same room. They both acquired Staphylococcus aureus 80, 81 infections that were penicillin resistant. Within one week, a nurse that had cared for both patients developed an infection on her right little finger, caused by the same organism. This nurse was dismissed from duty until the lesion had healed.

During the same interval, a patient on the same floor developed a postoperative wound infection caused by the same organism. One month later, a patient on the same floor developed an infection caused by the same organism in a stab wound established to drain the site of a nephrectomy. A causal link between the two burn patients and the attending nurse is obvious. However, whether the nurse introduced the infection to the burn patients or contracted it from them is not known. A causal link between the burn patients and the two patients that developed postoperative wound infections could not be established.

The outbreak of Staphylococcus aureus 80, 81 infections that occurred in the fall of 1961 was also investigated and is diagrammed in Figure 1. The first evidence of infection developed in Patient A on the fourth floor with a penicillin sensitive organism. Patient A developed a staphylococcal pneumonia following a total colectomy for fulminating ulcerative colitis. Large doses of corticosteroids were administered during his treatment as well as antibiotics. About two weeks later, Patient D was admitted to the fourth floor for an abscess on the right thigh. This was a penicillin resistant Staphylococcus aureus 80, 81 infection. Patient B was then found to have an infection in the incision for an open reduction of a fractured hip. Patient B was infected with two Staphylococcus aureus 80, 81 organisms, one sensitive to penicillin and the other resistant to penicillin.

During this same interval, an employee

ORGANISMS ASSOCIATED WITH NON-SURGICAL INFECTIONS WHEN COAGULASE POSITIVE STAPHYLOCOCCUS AUREUS WAS NOT PRESENT

| | Hemolytic Strep. | Strep. Viridans | Pneumo-coccus | Non-Hemolytic Strep. |
|---|---|---|---|---|
| Urinary tract infection | 4 | | | |
| Gastroenteritis | | | | |
| Decubitae | 1 | | | |
| Burn | | | | 1 |
| Skin abscess | | | | |
| Pneumonia | | | 3 | |
| Upper respiratory infection | 1 | | | |
| Septicemia | | 2 | | |

| | Coliform Proteus P. aeruginosa Paracolon | Coag. Neg. Staph. | Shigella | Salmonella |
|---|---|---|---|---|
| Urinary tract infection | 2 | | | |
| Gastroenteritis | | | 1 | 1 |
| Decubitae | | | | |
| Burn | 3 | | | |
| Skin abscess | 1 | 1 | | |
| Pneumonia | 3 | | | |
| Upper respiratory infection | | | | |
| Septicemia | 2 | | | |

TABLE X

working on the fourth floor developed an abscess caused by a penicillin sensitive Staphylococcus aureus 80, 81. An x-ray technician developed a carbuncle caused by a penicillin sensitive organism. On the basis of the time the infections were first detected, it would appear that this train of events was started by Patient A. The method of transmission is not known. It can only be said that these individuals were all potentially exposed to one another. The difference in antibiotic sensitivity indicates

DISTRIBUTION OF INFECTIONS BY HOSPITAL SECTION

| | | | Number of Patients With Pathogenic Cultures | |
|---|---|---|---|---|
| Hospital Section | Floor | Number of beds | Total | Acquired |
| Nursery | Fourth N. | 26-35 | 60 | 38 |
| Obstetrics | Fourth N. | 26-35 | 16 | 1 |
| Pediatrics | Fifth | 24 | 998 | 19 |
| Surgery | Fourth S. | 25 | 297 | 66 |
| Surgery | Third | 54 | 493 | 119 |
| Medicine | Second N. | 28 | 355 | 31 |
| Medicine | Second S. | 29 | 292 | 32 |
| Psychiatry | Second W. | 11 | 1 | 0 |
| Personnel | | | 253 | 19 |

TABLE XI

TOTAL ORGANISMS CULTURED

| | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 |
|---|---|---|---|---|---|---|
| Staphylococcus aureus: | | | | | | |
| Penicillin sensitive | 189 | 244 | 258 | 223 | 247 | 284 |
| Penicillin resistant | 98 | 95 | 55 | 164 | 132 | 129 |
| Hemolytic strep. — Group A | 57 | 21 | 24 | 29 | 35 | 60 |
| Nonhemolytic strep. | | | 3 | 9 | 11 | 13 |
| Pneumococcus | 68 | 64 | 24 | 7 | 19 | 45 |
| Coliform | 1 | 17 | 44 | 53 | 71 | 86 |
| Pseudomonas aeruginosa | | 9 | 18 | 38 | 45 | 31 |
| Proteus | | 24 | 29 | 32 | 32 | 50 |
| Strep. viridans | | 1 | 4 | 20 | 59 | 71 |
| Strep. fecalis | | 4 | 13 | 23 | 4 | 5 |
| Enterococcus | | 4 | 5 | 3 | 4 | 3 |
| Alcaligenes fecalis | | | 3 | 8 | 8 | 15 |
| Clostridium perfringens | | 4 | 5 | 3 | 3 | 7 |
| Clostridium tetani | | | | 1 | | |
| Paracolon | | 1 | 1 | 9 | 11 | 16 |
| Candida albicans | | | 1 | 2 | 1 | |
| Cryptococcus neoformans | | | | | | 1 |
| Fungus | | | 1 | 2 | 4 | 9 |
| Salmonella | 1 | | 1 | 7 | 7 | 6 |
| Salmonella typhimurium | | 1 | 1 | 3 | 3 | 1 |
| Salmonella Panama | | | | 1 | | |
| Salmonella infantis | | | | 3 | | 1 |
| Salmonella Newport | | | | 1 | | |
| Salmonella Derby | | | | | | 1 |
| Salmonella choleraesuis | | | | | 1 | |
| Shigella | | 1 | | | | |
| Shigella sonnei | 2 | | 1 | 2 | 1 | 1 |
| Shigella Flexneri | | | | 5 | 4 | 4 |
| Meningococcus | 3 | 1 | 1 | | 1 | 4 |
| Hemophilis influenzae | | 2 | 1 | 25 | 34 | 53 |
| Neiseria catarrhalis | | | 1 | | | |
| Gram positive bacillus | | | | | 8 | 12 |
| Gram negative bacillus | | | | | 12 | 13 |

TABLE XII

that two different organisms were present.

Patient C was also present on the fourth floor during this outbreak. However, he developed no apparent infection and was dismissed without a culture being taken. One month later, in September, patient C was re-admitted to the third floor with an infection caused by a penicillin resistant Staphylococcus aureus 80, 81. Within one month, two other patients on the third floor developed infections with the same organism. Patient C had an infected foot and required a supracondylar amputation. Patient E had an infected labium following a skin graft. Patient F had an infected incision following hip pinning. A causal relationship between Patients C, E, and F cannot be proved, but they were the only known patients infected with this type of organism during these two months on the third floor and all three had had surgery.

### Lysogenization

The limitations of routine phage typing in epidemiologic studies have been pointed out.[11] Distinct subtypes within the major groups 80/81, 52/52A/80/81 and 52/52A/80 have been demonstrated. Thus, the identity

## HOSPITAL-ACQUIRED INFECTIONS

| Organisms Cultured | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | Total |
|---|---|---|---|---|---|---|---|
| Staphylococcus aureus: | | | | | | | |
| Penicillin sensitive | 14 | 24 | 28 | 21 | 24 | 16 | 127 |
| Penicillin resistant | 20 | 19 | 14 | 34 | 19 | 26 | 132 |
| | | | | | | | (259) |
| Hemolytic strep.—Group A | 9 | 1 | 1 | 2 | 4 | 2 | 19 |
| Pneumococcus | 1 | 2 | | | 1 | 1 | 5 |
| Coliform | 1 | 5 | 7 | 8 | 11 | 16 | 48 |
| Pseudomonas aeruginosa | 1 | 2 | 3 | 7 | 7 | 3 | 23 |
| Proteus | | 3 | 6 | 4 | 5 | 10 | 28 |
| Streptococcus viridans | | 1 | | 3 | 12 | 13 | 29 |
| Streptococcus fecalis | | 2 | 1 | 6 | 2 | 1 | 12 |
| Enterococcus | | 1 | 2 | | | | 3 |
| Alcaligenes fecalis | | | 1 | 1 | 2 | 2 | 6 |
| Clostridium perfringens | | | 1 | 1 | 1 | 3 | 6 |
| Paracolon | | | 1 | 4 | | 2 | 7 |
| Candida albicans | | | 1 | 1 | 1 | | 3 |
| Fungus | | | 2 | | 1 | 1 | 4 |
| Coagulase negative staph. | | | | | 9 | 7 | 16 |
| Non-hemolytic streptococcus | | | | | 5 | 3 | 8 |
| Salmonella | | | | | 1 | | 1 |
| Salmonella Derby | | | | | | 1 | 1 |
| Shigella sonnei | | | | | | 1 | 1 |
| Gram negative bacillus | | | | | | 3 | 3 |
| Gram positive bacillus | | | | | | 2 | 2 |
| | | | | | | | (225) |

TABLE XIII

## HOSPITAL-ACQUIRED INFECTIONS
## STAPHYLOCOCCUS AUREUS ONLY

| Phage Types Occurring More than Once | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 | Total |
|---|---|---|---|---|---|---|---|
| Staph.a., Non-typable * | 3 | 8 | 2 | 5 | 1 | | 19 |
| Staph.a., Non-typable | | 1 | 6 | 6 | 3 | | 16 |
| Staph.a., Va4,77,79 * | 2 | | | | | | 2 |
| Staph.a.,80,81 * | 6 | 1 | 8 | 5 | 1 | 1 | 22 |
| Staph.a.,80,81 | | | 5 | | | | 5 |
| Staph.a.,80,81,52A * | | | | 3 | | 2 | 5 |
| Staph.a.,80,81,52A,3A * | | | | | | 2 | 2 |
| Staph.a.,3A * | | | | | 1 | 1 | 2 |
| Staph.a.,3A | | | | | 1 | | 1 |
| Staph.a.,Va4,77 * | | 2 | 1 | | | | 3 |
| Staph.a.,Va4,77 | 1 | 3 | | | | | 4 |
| Staph.a.,77 | | 1 | | 5 | | | 6 |
| Staph.a.,77 * | | | 4 | 6 | | | 10 |
| Staph.a.,53 * | | | | 2 | | | 2 |
| Staph.a.,47,53,75 | | | | 2 | | | 2 |

TABLE XIV

INCIDENCE OF STAPHYLOCOCCUS AUREUS 80, 81

| | Jan. | Feb. | Mar. | Apr. | May | June | July | Aug. | Sept. | Oct. | Nov. | Dec. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1959 | | | | | | | | | | | | |
| Total | 1 | 1 | | 1 | 1 | | | | 2 | 5 | 2 | 2 |
| Acquired | | | | | | | | | 2 | 2 | 2 | |
| 1960 | | | | | | | | | | | | |
| Total | | | 1 | | 1 | | | 1 | 1 | | | 2 |
| Acquired | | | | | 1 | | | | | | | |
| 1961 | | | | | | | | | | | | |
| Total | | 1 | 1 | 1 | | 3 | 1 | 7 | 3 | 5 | 4 | 1 |
| Acquired | | | 1 | | | | | 4 | 2 | 4 | 2 | |
| 1962 | | | | | | | | | | | | |
| Total | 1 | | 2 | | 1 | 3 | 3 | 1 | 4 | 2 | 2 | 2 |
| Acquired | | | 1 | | | | | 1 | 1 | | 1 | 1 |

TABLE XV

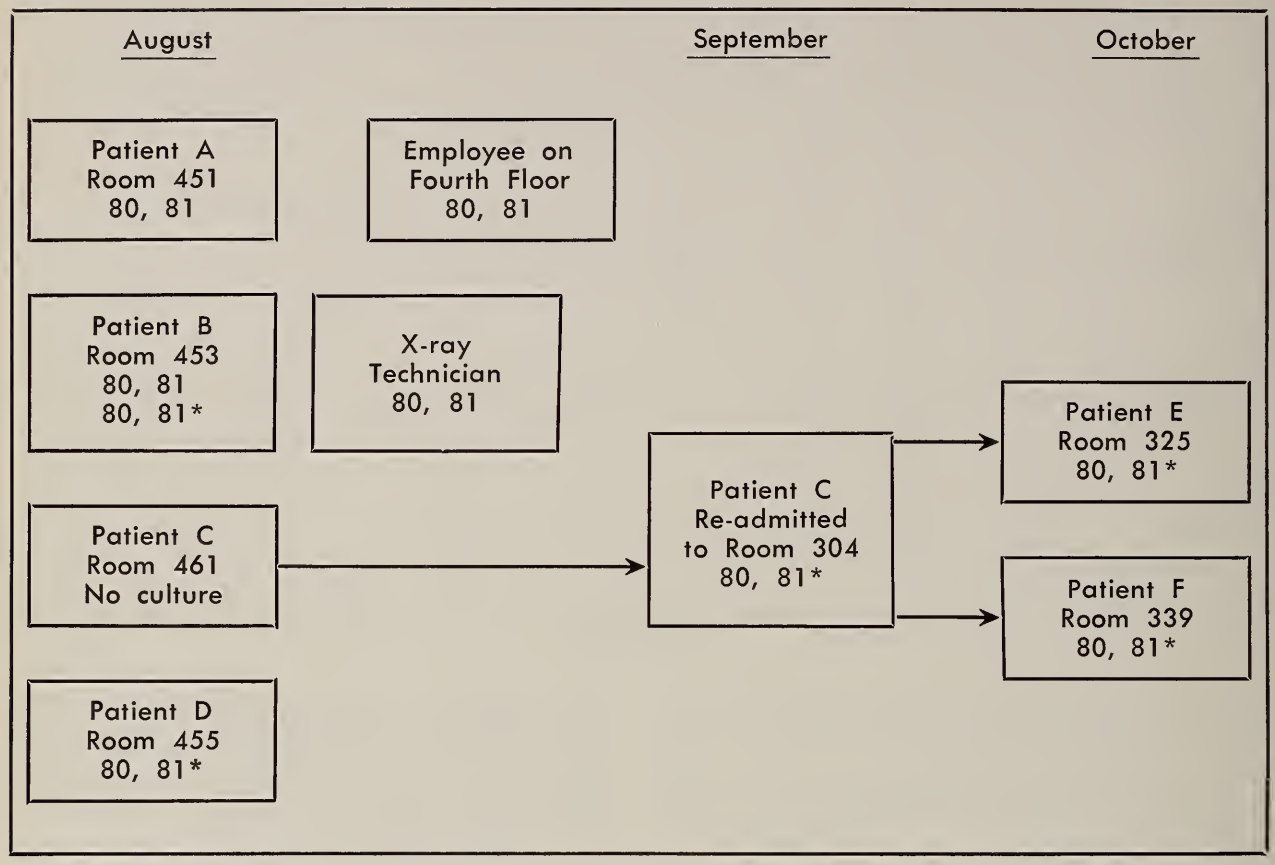
of two organisms with the phage type 80/81 cannot be determined with certainty without subtyping. Furthermore, one phage type can be changed to another by the process of lysogenization, as 52/52A/80 to 80/81. The problem arising from the possibility of lysogenization was illustrated when two children infected with Staphylococcus aureus, phage type 3A, were both attended by a pediatrician from whose nasopharynx Staphylococcus aureus, phage type 80, 81, 52A, 3A was cultured. With only routine phage typing available, the relationship between these phage types could not be determined.

The immediate recognition of the presence of a problem with infection within the hospital was dependent upon the alert, daily observations of the nursing department and clinical pathologist. Whenever a problem was suspected, the chairman of the Infection Committee, the attending physician and the administrator were notified for an emergency meeting. In June of 1963, the pathologist noted that two postpartum patients had developed streptococcal infections. An investigation was conducted and it was discovered that there were no known infections in any of the personnel. The patients had different doctors, were delivered on different shifts and were assigned different rooms. A common factor was not discovered. The obstetrics section was alerted and no further trouble developed. Incidents such as this should be brought to the attention of the medical staff and nurses so as to restore awareness of the ever present danger.

While there has been no definite study, the impression gained from reviewing the charts was that morbidity from hospital-acquired infections was slight in the great majority of cases. During the six years studied, there have been seven deaths attributable, in part, to hospital-acquired infections. One was the premature infant. Five were adults in which the infection was a terminal event in a life-threatening illness. One had uremia from diabetic nephropathy, one fulminating ulcerative colitis, one a bout of acute pancreatitis, one had a severe burn and was catheterized and one had cirrhosis of the liver with bleeding from esophageal varices. One elderly male patient died of bronchopneumonia and pyelonephritis after a suprapubic cystotomy. The great majority of hospital-acquired infections were considered more of a nuisance than a threat to the infected patient.

There is no doubt that the good results were in great part attributable to the availability of potent antibiotics. The problem

STAPHYLOCOCCUS AUREUS 80, 81 OUTBREAK IN 1961
ILLUSTRATING THE CHRONOLOGY, PHAGE TYPE AND LOCATION
IN THE HOSPITAL




* Penicillin Resistant

FIGURE 1

of antibiotic resistance is well illustrated by the fact that one-half of all the staphylococcal organisms causing hospital-acquired infections were resistant to penicillin. Some control on antibiotic use in the hospital was contemplated, but never put into effect. Continued observation failed to reveal any significant misuse of antibiotics that would account for infections in the hospital.

## Conclusions

This study has not revealed any new method for preventing and controlling infections in hospitals. It has demonstrated the application of the known principles of aseptic technic, early recognition of infection and isolation in a community general hospital. The data obtained have served a useful purpose in keeping the entire hospital and the medical staff aware of the problem of infection. The data have been the subject matter for repeated announcements at staff meetings concerning the state of infections within the hospital.

Analysis of the data has pointed out several deficiencies, including the need for better follow-up after the patient is dismissed from the hospital. The main goals for the future will be three: maintenance of a program of regular surveillance; continuing education in the problem of infection; and maintenance of a state of alertness to the first signs of spreading infection.

## Acknowledgment

I wish to acknowledge the cooperation of the medical staff, the clinical pathologic department, the nursing department and the hospital administration. The help of the Director of the Nursing Service, Mrs. Rusche R. Schutt, R.N., was particularly valuable in collecting and organizing the data.

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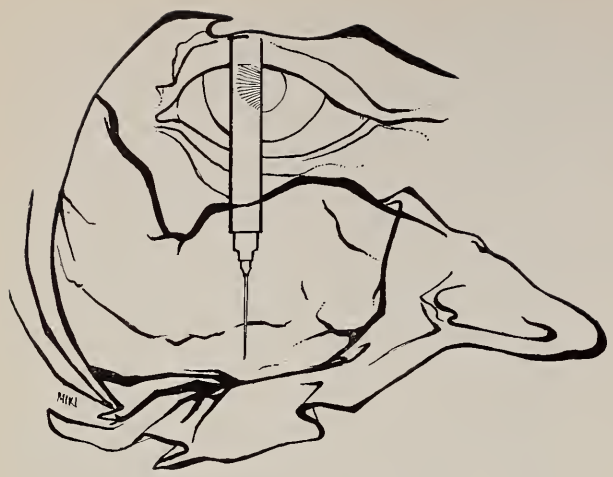
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## From *The Journal* 50 Years Ago

For several years efforts have been put forth to promote international peace, and the Carnegie Endowment was established to assist in that purpose. The great Peace Palace erected at The Hague was supposed to be a forerunner of a state of mind on the part of nations that would result in a speedy disarmament; yet while the leading nations of the world were sending envoys to peace congresses, those same nations were bending every energy to perfect their armies and navies, and the present tremendous war raging in Europe is mute testimony of the fact that no lasting peace can be expected as long as nations continue to appropriate millions for defense.

The efforts of the Peace Commission have been wasted, and Mr. Carnegie must feel that his endowment for international peace is mere mockery in the face of a war the like of which has never been seen in the history of the world. When the end comes, as come it will, there will be little or no need for the Carnegie Endowment for National Peace, for the people of the world will demand that such an unnecessary and wholesale destruction of life and property shall not occur again, and we look for the general adoption by all nations of a plan which will put into effect the arbitration of all differences and the cessation of all army and navy expenditures except those required to dispel internal disorders . . . . Editorial, *JISMA*, April, 1915.



# The Case of the Dangle Over the Divergent Diagnoses

ARNOLD LIEBERMAN, M.D.
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DIAGNOSIS must precede all but the most elementary, empiric, symptomatic therapy. The doctor has to know the what and why of events; also, the possible course of things to be expected. At times, the diagnosis is obvious; at others, it takes a *lot* of doing. To complicate matters still further, the obvious can become progressively less so. Just when we think we are all set with anchors aweigh: our cables fray and we are left with anchors awry! Which brings me to Gloria Jones.

One hectic morning, a hurried call came from the emergency room, "Arnold! we are rushing a dying, 30-year-old woman upstairs. Yes, I know you have no beds; leave the stretcher in the anteroom. It's a ruptured berry aneurysm—found unconscious in her apartment by a neighbor—four small children—pupils dilated—stiff neck! Thanks!" The phone clicked before I could get a word in edgewise.

Only seconds later, the elevator doors swung open and the cart was wheeled into the corridor. The inevitable $0_2$ mask was strapped to the patient's face. She was breathing convulsively, every gasp seeming the terminal one; the skin was cold and clammy and I could get no pulse. No other help being obtainable; I detained the attendant and turned the woman on her side. I plunged the lumber puncture needle into her bared back.

In retrospect, I realize that a cisternal maneuver would have saved many nagging perplexities that plagued us later. Probably, because of the presence of ward visitors, I performed the seemingly less terrifying procedure. Mind you! The familiar maneuver is no feat. I am old enough to have been trained (in the ante-sulfonamide era) to treat infectious meningitides by the *lavage* of the spinal canal: injecting saline into the needle nestled within the cisterna magnum and aspirating from the needle within the spinal canal. I am well aware that my younger colleagues are condescendingly tolerant of my penchant for cisternal punctures. Well, to me, it is easier than the percutaneous femoral and common carotid artery transforations *they* do with such enviable insouciance.

### Death Defied

Anyhow! The lumber puncture was effortless: almost pure blood spurted out! The "obvious" diagnosis given to me on the telephone appeared confirmed. Three large tubes filled quickly as some 50 cc. were drawn. The initial gush slowed to a diminishing dribble and then stopped altogether. An important argument for cisternal drainage is the fact that it avoids the possibility of brain-stem herniation when spinal fluid is evacuated too rapidly via the lumbar route. I had had no time to worry about this complication! On the contrary, the patient's response to my maneuver was no less than spectacular. Teetering on the very brink of death, the gasping breaths slowed, evened and became a steady succession of normal respirations. The pulse became palpable and the heart was readily auscultated. By the time the stretcher could

be eased into an aisle space, the all but dead patient was showing signs of returning consciousness! There had been no ward personnel present to witness the drama of the anteroom. On the chart there is only the brief note, "patient placed on critical . . . bloody spinal tap by Dr. Lieberman . . . ."

Within the hour, the patient was taking fluids by mouth even if a precautionary I.V. had been started and a Foley catheter had been inserted. We were delighted to see the apparent cessation of the subarachnoid hemorrhage. These things *CAN* happen spontaneously. Cases are described in the literature.*

In fact I can cite an instance in my own family. A 32-year-old nephew collapsed suddenly while abroad. He recovered sufficiently to be flown to the big American installation at Wiesbaden, Germany. There, the neurosurgeons did a left frontotemporal craniotomy: the subarachnoid hematoma was evacuated from the surface of the temporal lobe; the berry aneurysm of the middle cerebral artery was isolated and clipped off without occluding the main lumen of the artery itself. The young man has recovered completely and is now back on his State Department job!

However, 95% of the ruptured berry aneurysms are fatal within the day. Four of the other five show grave residues. My nephew is within the lucky one percent!

The young woman's rapid recovery was all but incredible. I had visualized a massive hematoma compressing the brain stem; pressure on the aneurysm had checked the hemorrhage just before impending exitus; the spinal tap relieved the almost lethal squeeze on the vital centers. Reversion of events *COULD* explain the nigh miraculous revival—or, could it?

### Dubious Diagnosis

Within three hours, I was doubting the "obvious" diagnosis made off-hand in the emergency room and—just as off-handedly—confirmed by me. I asked another attending, my friend Dave, to please repeat the




spinal tap. He had some slight difficulty in getting in but what he got was unmistakable spinal fluid: at first, frankly bloody, then, xanthochromic; the last tube was crystal clear! Was this initial blood merely a traumatic mechanical affair or was it the very last of the hemorrhage that I had not withdrawn? Was the clear fluid new secretion by the Pacchionian bodies in the ependyma?

Still another hour later, the neurologist came in consultation. By that time we had also obtained the results of some stat. laboratory work. The c.b.c. showed a Hb of 15 gm., white blood count of 6,000 with a normal differential—sedimentation rate of 30. Urea nitrogen was 13, glucose-70, Ca-9.4, P-2.9. The last two tubes of the spinal fluid were analyzed for cell count, protein, sugar, etc.: all were within normal limits. Rectal temperature was 100° F; pulse-95; blood pressure 120/70.

Quoting the consultant: "responds to deep pain . . . will stick out tongue when requested . . . equivocal Babinski right side. Impression: post-ictal state; rule out barbiturates; not surgical now . . . observe . . . do skull films and electroencephalogram." He accepted the woman to the surgical service.

Even before the transfer, the patient

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began to display generalized, athetoid movements. There was neck stiffness, most noticeable on attempts at lateral flexion; rhythmic flexions of the extremities became progressively more conspicuous; alalia was produced by chomping tremors of the tongue and jaw. There was no temperature rise; all vital signs remained well maintained; there was salivation but no drooling, thus indicating ability to swallow.

On the surgical service, a procession of attendings examined the patient; with each review the picture became ever more obfuscated. At 8 p.m. the blood pressure was 155/110; she was able to say that she had taken no pills beyond an aspirin at 6:30 a.m. Shortly thereafter, she had visited with her neighbor; after returning to her apartment, she had "blacked out."

One of the neurologists suggested the possibility of viral encephalitis: a stool specimen was sent to the Board of Health; simultaneously, a clotted blood tube was set aside to await the second serum specimen to be obtained two weeks later for comparison. A psychiatric eminence obnubilated things still further by suggesting the possibility of schizophrenia!

### Domestic Details Disclosed

All agreed that surgery was not indicated for the present time. The blood I had obtained in the first tap was dismissed as "venous penetration." So for the next week, things remained in status quo. The neighbor lady came to visit the patient; she had nothing to add to the tale beyond the already known fact that (to her) the patient had appeared to have been entirely well 15 minutes before being found unconscious on her kitchen floor. This informant also volunteered to contact the patient's husband. A couple of days later, this gentleman showed up; he was not backward about talking. His wife had always been a very vigorous, dominating woman. He had felt forced to leave her as he just could not contend with her nagging, shrilling abuse. He wanted to take care of the children after obtaining a divorce. Yes, he had found another, "very fine" girl companion. His wife had been very vehement on the subject. Also he told me several unprintable things about his wife. If true, she must have been a veritable termagant; it was the four small children who were the chief sufferers. The husband told me he feared for their very lives.*

By the end of the second week, it had become completely obvious that no surgery would be performed. The patient was improving slowly but steadily. The bizarre, extra-pyramidal signs persisted even if the E.E.G.'s remained, "within the limits of normal." Perforce, Gloria was returned to the medical service.

The patient's temperature and pulse as well as all the standard laboratory parameters remained within normal limits. A resident did note, "some induration and tenderness in calf muscles suggestive of low grade thrombophlebitis." A repeat neurological consultation elicited the suggestion that, "artane or cogentin could quiet her movements enough so that she could feed herself." This was done and the nursing problem became somewhat eased.

About this time, an urine specimen was found to have blood. This was attributed to menses; however, a catheterized sample still showed blood so further procedures were undertaken. Pelvic examination showed a fibromatous uterus without adnexal masses being palpable. Bladder irrigations cleared the hematuria. Because of the patient's precarious condition, cystoscopy was postponed.

At the end of the third week in the hospital, the patient was gone over by still another neurologist and myself. She seemed to be much improved. She was fully conscious; the bizarre muscular gyrations were being fairly well controlled although the tongue twisting tremors still made speech all but unintelligible. After a review of the history and the progression of events in the hospital, we rather agreed that a viral encephalitis could explain the entire picture. The resident drew blood specimens for a repetition of the standard tests; also, a tube of clotted blood was set aside to go to the Board of Health as the second of the two tubes for viral titer observations. At this examination, neither the neurologist or I could elicit any signs of any thrombophlebitis in the legs.

---

* Battered Child Syndrome.

**Death Indomitable**

The very next morning, Gloria Jones collapsed suddenly into shock: pulse went to 160—thin and thready; blood pressure-105/95. Emergency E.K.G. disclosed a 3:1 atrial flutter; chest film showed, "hazy infiltrations." The diagnosis of pulmonary embolization was made; aramine was given via a cutdown; the entire gamut of antishock procedures was initiated. Nevertheless, the temperature, continued its steep rise from 98° to 106°, the stat. c.b.c. showed 21,000 leukocytes and "toxic granulations" were noted. The gynecologist did not believe that there was anything for him to do. The general surgeon went along with the diagnosis of pulmonary embolization and acute endotoxic shock. All agreed that the use of massive doses of corticoids, antibiotics and blood transfusions offered the only slim hope for survival. In spite of all the concentrated therapy, Gloria Jones was pulseless by noon—no blood pressure could be recorded. The temperature continued mounting to an uncontrollable 108°; respirations ceased at one p.m. Cardiac massage, artificial respiration, etc. were attempted before she was—finally—pronounced dead.

An autopsy was performed within four hours of death. The acute pulmonary emboli had come from mural thrombi in the right auricle. They were sufficiently massive to explain the sudden collapse preceding the lethal termination. An examination of the brain showed numerous focal arterial thrombi and cerebral softening chiefly within the thalamus but scattered through other regions as well. The organization and early scar formation was compatible with the three week history of the disease. The pathologists failed to find any signs of a berry aneurysm in the Circle of Willis. They did not dissect the leg blood vessels.

The specimens of blood sent to the Board of Health for viral studies got lost so that our diagnostic essays got no help from that source. It was very hard for me to maintain that an aneurysm *HAD* ruptured, *HAD* caused an extravasation and that enough pressure on the brain stem had been produced to display the clinical picture I had witnessed. Where was the leak that I said




had sealed itself? What but the spinal tap could have removed the compressing fluid and thus have produced the startling clinical improvement I had witnessed?

In retrospect, I concur most heartily in saying I should have done a cisternal puncture. Rather feebly, I do say that a resealed break in an artery could have healed over completely in that three week period, so that a gross pathological dissection *could* be completely unrevealing.

Could the original sudden collapse have been from *LEFT* auricular thrombi embolizing the brain? Also, my very splendid young neurologist colleague points to the shadowy possible leg thrombophlebitis, "After all, at postmortem the lower limbs were not dissected at all . . . ."

Then there are such rather rare, little understood entities as idiopathic leukoencephalitic necrotizing vasculitis, "shortened" to necrotizing leukoencephalopathy! Rather than confessing confusion, we could attach this formidable terminology and challenge the listener to come up with something better. All in all, however, polysyllabic stuttering is not *really* satisfactory.

What had started out as a simple, obvious, open and shut case, had progressed to a hopelessly tangled skein of contradictions: a *Disjointed Dangle* of *Dismayingly Divergent Diagnoses!* It is some consolation to know that it matters no longer as to who was or was not right even if the orderly mind does seek logical answers.

There is, however, one interesting sequel to the tale. The widowed husband of Gloria Jones is now free to marry the young lady of his choice. It becomes probable that the four children may find a pleasant home;

Social Service may be rid of a rather sticky problem.

And another thing! A cisternal tap has become less of an anachronism and demonstrably a maneuver that may give answers otherwise unobtainable. ◄

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## About Our Cover

The medical dictionary's definition of cancer is "any malignant tumor, made up chiefly of epithelial cells."

Were that it were only that simple to find out its cause and thus divest man of its all-encompassing tentacles.

For over 50 years it has been known that viruses can cause tumors in animals and it has long been suspected that they do in man. Yet the actual "how" and "why" of this transformation remains one of modern man's most frustrating and complex enigmas.

Latest steps taken in man's seemingly never-ending battle against cancer are plans for a network of regional medical complexes across the nation to assist in combating heart disease, cancer and stroke. President Johnson has planned the network and legislation is pending.

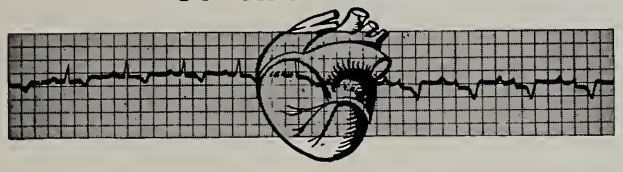
The solution is there and the answer will be found.

April has been designated as crusade against cancer month. The new 5-cent stamp on this month's cover commemorates the fight against cancer and was issued April 1. Stevan Dohanos, American artist, designed the stamp.—J.F.S.

**NEXT MONTH IN *THE JOURNAL***

**Drs. Joe Noble and Roy H. Behnke, of Indianapolis, will present a comparison of the PPD with the Tuberculin Tine test as performed on 75 patients at the Veterans Administration Hospital.**

# Electrocardiogram of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Ventricular Premature Beats due to Vagal Stimulation*

*CHARLES FISCH, M.D.*
*Indianapolis*

IT IS commonly accepted that the vagus does not influence the mammalian ventricular muscle because its fibers do not reach these structures. On rare occasions however, the appearance of ventricular ectopic beats have been recorded following stimulation of the vagus, suggesting that at least in some cases the vagal fibers do innervate the ventricles.

Such a rare example is depicted in Figure 1. The basic rhythm is atrial flutter with a 2:1 atrioventricular response. With onset of carotid stimulation, the degree of block promptly increased to 6:1 and three ventricular premature systoles (V.P.S.) coupled to the "normal" ventricular complex by .36, .44 and .44 seconds respectively appeared. The difference in coupling as well as in morphology suggests that the first V.P.S. originated in a focus different from that which gave rise to the second and third V.P.S. With cessation of vagal stimulation, the flutter promptly resumed its original 2:1 block. ◄

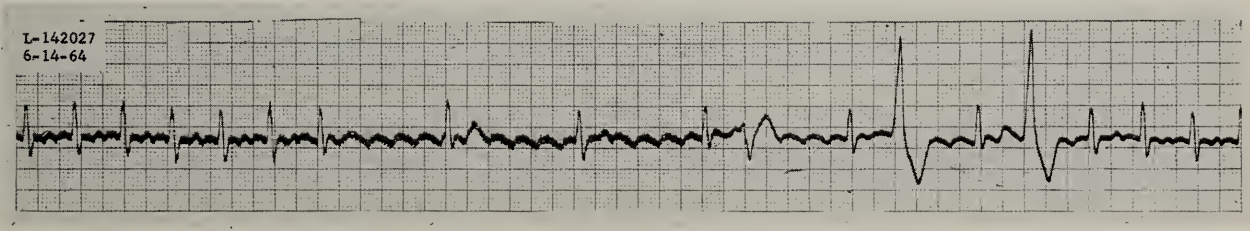



**FIGURE 1**

**ATRIAL FLUTTER with slowing of ventricular response and appearance of ventricular ectopic beats with vagal stimulation. For details see text.**

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Metastatic Melanoma of the Right Atrium and Superior Vena Cava

*ERICH K. LANG, M.D.**
*Indianapolis*

A 24-year-old white female patient was admitted with a complaint of swelling of the right arm. Physical examination revealed minimal distention of the veins on the dorsum of the hand and of the jugular vein. There was no significant discoloration or increased temperature of the extremity. The chest roentgenogram was normal.

To differentiate between a venous obstruction and lymphatic edema, a venogram of the right forearm was performed. Forty ccs. of 50% Hypaque were injected and serial films were taken demonstrating the veins of the arm, the subclavian vein and superior vena cava. There appeared to be considerable stasis and dilatation of the post-valvular segments of the veins and reflux into the jugular vein. The most significant finding, however, was transport of dye over the azygos system due to an apparent complete obstruction of the superior vena cava at its point of entry into the right atrium.

A second series of films of the mediastinal area demonstrated an oval shaped filling defect in the superior vena cava below the point of entry of the azygos vein (Figure 1). Likewise, there was a huge filling defect in the upper portion of the atrium with practically complete obstruction of the inlet of the superior vena cava. These defects were felt to be caused by either an intravenous thrombus, a tumor mass extending directly into the superior vena cava and right atrium or possibly an atrial myxoma. The right atrium finally filled via the inferior vena cava. The contrast medium was shunted over the azygos system into the inferior vena cava and then emptied into the right atrium.

Further investigations during this hospital admission failed to render a definitive diagnosis.

The patient continued to be plagued by increasing edema, now present in both upper extremities. Increasing symptoms of a superior vena cava obstruction were evident. The patient was referred to Memorial Hospital in New York. Exploration of the mediastinum and a radical node dissection of both axillae furnished material for a histopathological diagnosis of metastatic melanoma. In retrospect, the patient was able to give a history of excision of several "pigmented moles" some three years prior to this admission. These moles were not examined histopathologically and were felt to be benign on the basis of their clinical appearance.

The patient was subjected to three courses of cytotoxic agents of the mustard family. Some improvement in the edema of the upper extremities was noted. After the third course of cytotoxic therapy, the

* Department of Radiology, Methodist Hospital.

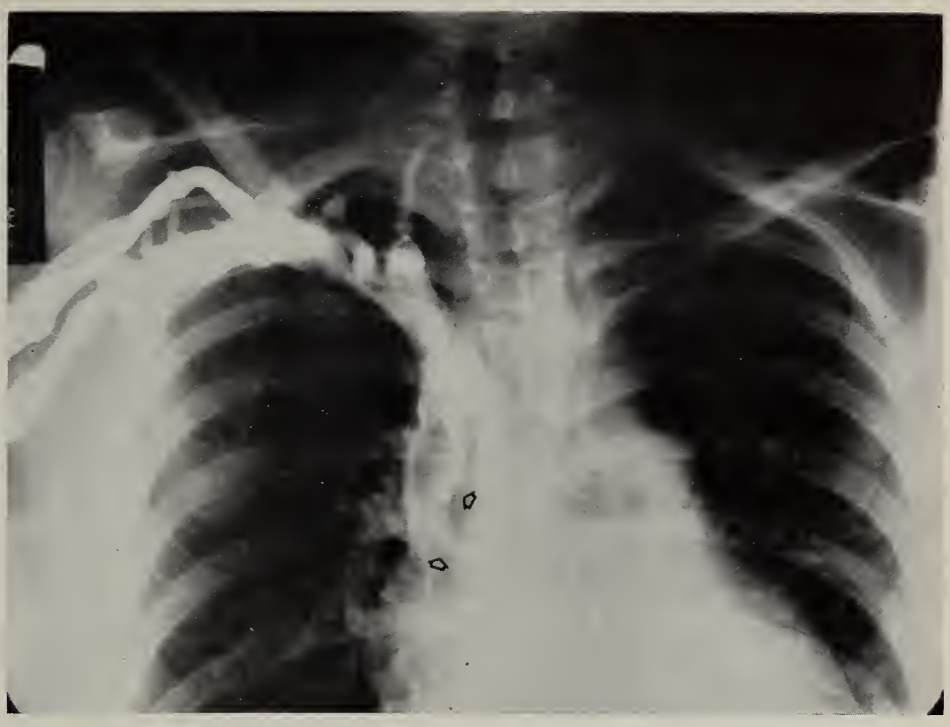


FIGURE 1
THE SUPERIOR VENA CAVOGRAM demonstrates dilatation of the axillary and subclavian vein in the post-valvular segments. There is reflux into the jugular vein. Prompt filling and dye flow over the azygos vein is demonstrated. Note the oval shaped filling defect in the superior vena cava and the large rounded cut-off of the dye column at the point of entry of the superior vena cava into the right atrium.

patient developed generalized alopecia and a profound anemia. Over the ensuing six months, the condition of the patient continued to deteriorate and she finally expired in a severely cachetic stage, with marked anemia, lymph node masses in the groins and neck and severe depression of her bone marrow.

At autopsy, huge masses of metastatic melanoma could be demonstrated in the paratracheal nodes, nodes in the area of the carina and in nodes along the right hilum. There was direct invasion into the superior vena cava and into the right atrium. The cut specimen showed complete obliteration of the superior vena cava at its point of entry into the right atrium. It was felt that these tumor masses represented direct extension of tumor into the cardiovascular system rather than metastatic implants. Extension of this tumor is similar to a thymic carcinoma that directly invades the pericardium and large vessels.

## Comments

The efficacy of venography and angiography of the superior vena cava in differentiation of the various types of edema of the upper extremities is illustrated by this case. The diagnosis of an obstructing mass in the superior vena cava and right atrium was made several months prior to the definitive diagnosis of the lesion. Venography of the upper extremities is considered to be particularly useful in the differential diagnosis of obstruction secondary to venous thrombosis, superior sulcus tumors (Pancoast tumors), mediastinal collangenosis, tumors of the mediastinum, central bronchogenic carcinomas, traumatic thrombosis of the axillary vein, thrombosis of the subclavian vein secondary to thoracic outlet syndromes and the rare thrombosis secondary to venous angiitis. Lymphangiography can be opportunely employed for further differentiation of lymphatic edema of the upper extremities, however this method is considered to be more difficult and less rewarding in the upper extremities because of selective filling of only one of the lymphatic trunks without complete demonstration of other lymphatic trunks and their node system. ◄

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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# I. U.'s Combined Degree Program

ALL PHASES of medical endeavor, whether in research or in practice, are intertwined with almost all of the scientific disciplines and most of the humanities. And there is every indication that progress will bring further elaboration of this concept.

The Combined Degree Program in Medicine at Indiana University was established with just this thought in mind. It is designed to combine the study of medicine with the study of and the earning of degrees in subjects which were once thought to be far removed from medicine.

The program at Indiana, which was begun in 1959, has already tutored students in the study of medicine coupled with courses leading to degrees in law, journalism, foreign languages, psychology, chemistry, physics and business.

The program director, Dr. Douglas A. MacFadyen, does not regard the program as an "innovation." "We think there should be more cross-fertilization of knowledge between the sciences and humanities. This is the way education used to be. It's an old-fashioned idea, really."

Aside from the cultural advantages, the new scheme of medical education carries many highly practical implications. All physicians should have a better knowledge of law and there are several medical specialties where an extended study of legal principles is essential.

As medicine advances on the rapidly developing foundations of pure science, complicated clinical studies are found to depend on mathematical, electronic, chemical and physical principles, and even on such a narrow and exacting science as bio-statistics. If such an educational background can be acquired during the same years that a medical education is achieved, how much better the two systems will intermesh when applied later in life.

All students who have completed their standard premedical education may, on applying for admission to Indiana University School of Medicine, elect which course they wish to follow. In the regular M.D. degree course, the student spends four years at the Indianapolis medical school campus and acquires an M.D. degree. If he chooses the Combined Degree Program, he spends three years on the Bloomington campus. In that time he accomplishes the medical subjects ordinarily given in the first two years at Indianapolis and in addition, does work in his field of special interest. He usually acquires a B.S. and an M.S. degree before proceeding to Indian-

apolis for the last two years of medicine and the M.D. degree. An additional year and the writing of a thesis will acquire a Ph.D. degree in medicine.

The program was established with the assistance of a grant from the Commonwealth Fund as a carefully designed experiment in medical education. It has the blessing of the American Association of Medical Colleges, as well as the AMA and the National Science Foundation. It is off to a good start and is now graduating the first of its small classes.

Much of its success is due to its director, Dr. MacFadyen, who exemplifies the objectives of the program. He holds the B.S., M.S., and M.D. degrees from the University of Toronto, has done research at the Rockefeller Institute and duPont Institute, was chief of the Division of Chemistry and Physics at the Army Medical School, is a champion chess player and accomplished musician, as well as occupying his spare time in research on classic literature.

## Illegal Drug Traffic

AMPHETAMINES and barbiturates are probably the two non-narcotic drugs which are most often used improperly today. Since both are prescription drugs, improper use can result only from their distribution outside proper medical channels.

The illicit trade is supplied either by unscrupulous persons who divert large supplies of legitimately manufactured drugs into "bootleg" traffic, or by a large group of equally unscrupulous persons who counterfeit the drugs especially for illegal purposes.

These two unlawful sources combined have created a gigantic problem which is becoming larger and which is one of the biggest law enforcement dilemmas of the Food and Drug Administration. In one year, New York State seized 131 different lots of spurious drugs made to imitate leading products.

The ethical pharmaceutical industry is similarly alarmed at the enormity of the illicit trade in amphetamines and barbiturates. It is cooperating to the fullest extent in the task of eliminating the counterfeit sources. One of the makers of amphetamine, Smith Kline & French Laboratories, have always dispensed it in such a way as to discourage improper usage and have tightened controls, including inventory control, to prevent diversion into illegal media.

Counterfeiting of pharmaceuticals not only is dangerous because of the irresponsible hands into which the products fall, but, due to the irresponsibility of the maker, the final product may vary in dosage or in quality and may not even contain any of the indicated drug. Such medicinals would be dangerous if used entirely by careful physicians.

The Congress has under consideration a bill, sponsored by Senator Thomas Dodd, designed to control the manufacture and distribution of amphetamines and barbiturates. The Pharmaceutical Manufacturers Association testified before committee hearings last year and again this year in support of this type of legislation, and has recommended changes in the bill to increase its effectiveness.

Highly effective control measures will be necessary since the profits of the illegal traffic are high. Everything possible must be done to eliminate the counterfeiters and to maintain legitimate supplies of these drugs in legitimate medical channels.

## Pharmaceutical Advertising

PHARMACEUTICAL advertising is included in a professional medical journal for two reasons. First, it provides the practicing physician with the latest information on the newest drugs; it amounts to a preview of the next year's pharmacopeia. Second, it is the pharmaceutical manufacturer's best method of introducing a drug to the

medical profession. In return for the presentation of a drug in a medical journal, the manufacturer pays a fee which helps publish the journal and in return for this the manufacturer sells the drug and makes a profit.

The following was noticed in Editorial Views of the January, 1965 issue of *Michigan Medicine*. It is an excellent exposition of the second reason!

"Whenever we organize the content of *Michigan Medicine,* we always begin with the pages of advertising that are sold to help make this publication possible.

"As we do this, we often ponder the piercing question, 'Does advertising pay?'

"*Michigan Medicine* firmly believes it does or we could not accept the advertising in good faith.

"One of the best answers to the question was given by Charles G. Mortimer, Chairman of General Foods Corporation, when he made this statement at a stockholders' meeting:

" 'Does advertising pay? It has to, or we could not continue to pay current dividends to you stockholders, or increase the volume of present products and introduce new products to provide better profits and dividends in future years. Yes, I believe we do get our advertising expenditures back—and with a profit.'

"We believe, too, that advertising is one of the most economical ways of stimulating mass sales, and mass sales keep prices down, permit companies to carry out research, to invest in modern plants, to provide a profit for their stockholders and to pay taxes to local, state and federal governments."

*Guest Editorial*

# 1965 AMA Annual Meeting

*DONOVAN F. WARD, M.D.*
*President, American Medical Association*

THE YEAR 1965 is a crucial year for American medicine. It is a year in which important and far-reaching events are transpiring that may have a long-lasting impact on how we practice medicine in America.

An outstanding highlight in medicine in 1965 will be the 114th annual convention of the American Medical Association, June 20-24 in New York City. It is our conservative estimate that more than 10% of all American physicians and perhaps as many as 15% of those in private practice will register for the New York convention.

Nowhere else in the entire world do physicians gather in such numbers to continue their medical education in an intensive short course that, literally, has something for everyone. Hundreds of scientific papers will be presented by the top medical scientists of our time, from foreign lands as well as our own country. Newest teaching films will be shown. Hundreds of scientists will offer exhibits in which the entire spectrum of medical progress in 1965 will be on view.

American physicians do not attend the AMA annual convention just to take a trip to New York, although that is an interesting sidelight. They attend because they have learned through the years that nowhere else can they find out so much about new developments in medical practice; where they can learn so many things that will be of inestimable value to them in their own practices.

The Council on Postgraduate Programs of the AMA has done an outstanding job in preparing the scientific programs for the 114th annual convention. This is the single most important medical scientific meeting in the world this year.

On behalf of your professional society, the American Medical Association, I urge personally that every physician in America attend the June convention.

# Editorial Notes...

**Tetracycline treatment can convert innocuous "carriers" of resistant staphylococci into active "spreaders" of the same organisms.** Carriers of a 52/52A/80/81 strain which was resistant to tetracycline and penicillin were found to transmit the bacteria only when large numbers of organisms were found in the nose. Apparently the carriers accumulated large numbers of pathogenic cocci when the sensitive nonpathogenic bacteria in the nose were reduced by tetracycline administration.

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**Skin contamination and colonization is being recognized as the most important factor in hospital infections.** Most postoperative surgical infections are due to organisms which by phage typing may be demonstrated to be present in and on the skin of the patient on admission to the hospital. A recent San Francisco symposium reported that, even in the case of hospital personnel who are nasal or throat carriers, the final transfer of the pathogen is accomplished by the nurses' or doctor's hands and not by the airborne route. Control of pathogens in and on skin is becoming more and more important.

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**A new antiseptic spray foam, especially useful for the decontamination of hands, was described at the above mentioned San Francisco symposium.** The product is produced by Johnson and Johnson and has demonstrated its usefulness in several hospitals. It contains 0.25% cetylpyridium acetate and 0.25% dequalinium acetate in 50% alcohol. It is especially useful for hand scrubbing preoperatively, for ordinary handwashing in the hospital and for the prevention of staphylococcal infections in newborn infants.

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**Deliberate colonization of the newborn with a nonvirulent strain of staphylococcus goes a long way toward preventing establishment of pathogenic staph organisms.** Strain 502A, isolated and tested at Cornell Medical Center, prevented staphylococcal lesions in all but eight percent when planted on newborns whereas the control group had an infection rate of 51%. Use of a similar culture at Cincinnati caused the 80/81 strain to disappear from the nursery. It gradually reappeared, however, when the "friendly" staphylococcus inoculation program was discontinued.

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**The packaging of pills and tablets in labeled double cellophane tapes is increasing.** Wyeth Laboratories has announced the addition of seven more drugs to this method, which is demonstrating many potential advantages, especially for hospital pharmacies. Reduction of errors in dispensing, maintenance of cleanliness while stored in the medication room at the nurses station, returnability and re-dispensability of unused dosages and the practical certainty that drugs cannot become mislabeled are some of the obvious benefits.

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**Research continues to validate the hypothesis that diets which lower the cholesterol and triglyceride content of the blood will spare the arteries of sclerosis and lower the mortality rate of coronary heart disease.** The "Anti-Coronary Club" of the New York Department of Health has over 1,000 members who have eaten the so-called "Prudent Diet" for seven years. A control group of 420 men have continued to eat as they had in the past. The "Prudent Dieters" have had only one-fourth as many heart attacks.

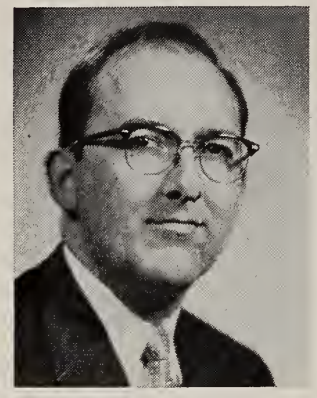
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**Pitman-Moore announces the licensing and general availability of a new measles vaccine.** The new product is a greatly attenuated live vaccine and can be given without an accompanying dose of gamma globulin. Previously marketed live vaccines have been slightly attenuated and globulin was necessary to lessen the fever and rash which the slightly attenuated virus produced. Killed vaccines produce immunity of short duration and must be repeated. The Pitman-Moore product, called Lirugen, is so attenuated that globulin is not necessary and is so highly antigenic as to produce long-lasting immunity. It has been under trial for three years and the earliest patients still possess immunity. Dr. Anton J. Schwarz, head of P-M's Virus Research, developed the vaccine and contributed his name to the strain of virus from which it is made. ◄

# President's Page

## *Our New Dean*

The Indiana State Medical Association received an injection of powerful tonic in physicians relations and public relations with the selection of Dr. Glenn W. Irwin, Jr. as Dean of the Indiana University Medical School. President Stahr and the Indiana University Board of Trustees must be commended for their selection.



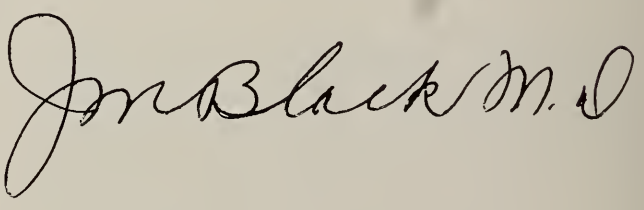
**Glenn W. Irwin, Jr., M.D.**

Dr. Irwin was selected by the officials after a screening committee consisting of members of the medical school faculty, university faculty at Bloomington, practicing physicians in Indiana, the president of ISMA and the president of the I.U. Medical School Alumni Association. This committee screened approximately 200 outstanding men in medical education. Their task proved most fruitful to our profession and our students.

All of you are aware of Dean Irwin's ability as a physician, teacher, administrator and of his interest in organized medicine. These attributes will intensify his qualification to be medicine's leader in Indiana.

I've been told, while traveling the state, by those interested in medicine, of their enthusiasm in the selection of our new dean. Dean Irwin is knowledgeable about medicine's problems. He is Indiana-educated and oriented and enthusiastically for our great state.

Congratulations and best wishes, Dean Irwin.



Recommended Dosage of Lomotil Liquid to Control Diarrhea

File: Diarrhea

# LOMOTIL®

| Age | INITIAL LOMOTIL LIQUID DOSAGE* |
|---|---|
| 3-6 mo. | ½ tsp. t.i.d. (3 mg.) |
| 6-12 mo. | ½ tsp. q.i.d. (4 mg.) |
| 1-2 yr. | ½ tsp. 5 times daily (5 mg.) |
| 2-5 yr. | 1 tsp. t.i.d. (6 mg.) |
| 5-8 yr. | 1 tsp. q.i.d. (8 mg.) |
| 8-12 yr. | 1 tsp. 5 times daily (10 mg.) |
| **Adult** | 2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.) |

*Based on 4 cc. per average teaspoonful.
**Note:** After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

# LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

**Precautions**
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

**Cautions and Side Effects**
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

# The Woman's Auxiliary

## REPORTS TO ISMA

For some time I have wanted to share information with you about our county auxiliaries. As a result of my recent Evansville visit, I have some facts to report about one of our larger groups.



The Vanderburgh-Southwestern Medical Auxiliary has 186 active members, many of whom are young and enthusiastic. Mrs. Martin J. Bender is their president. They have seven "luncheon meetings" a year, an annual dinner-dance and a "Christmas coffee" with their nurse scholarship students as honored guests. Their nurse scholarship loan program provides a $400.00 scholarship for three students a year; it is set up on a rotating basis and is self-sustaining.

AMA-ERF has been a priority project with this group for many years. Their most effective money making project to date is a simple Christmas card sent to physicians' families bearing the printed names of senders who have contributed to AMA-ERF in the amount ordinarily spent for cards. A "Talent Action" for which members donate homemade items such as baked goods, hand sewn articles, knitted wear, paintings, ceramics, etc., and for which a professional auctioneer has donated his time, has proven to be both entertaining and profitable for their AMA-ERF funds. A "Brunch-Bridge" for which members donate food services and proceeds to AMA-ERF has also become an annual event.

Mrs. Robert Harris is the editor of the "Vanderburgh-Vein," a quarterly newsletter sparked with items concerning auxiliary members and their families and with timely messages from auxiliary officers and chairmen.

In compliance with a request from the local Red Cross, a file of auxiliary members with special training is being compiled for the Red Cross in case of a Civil Defense emergency and also for use within the auxiliary.

A substantial gift is contributed annually to the state hospital in Evansville and for many years the *Today's Health* magazine has been sent to all Vanderburgh county schools. They are active with all other auxiliary projects and are continually working to improve their business system and procedures.

FLASH: For the first time a "special issue" of *The Hoosier Doctor's Wife* is being published. It will contain pertinent facts about both the "medicare" tax plan and the doctors' Eldercare program. Read it and let others know its content.

As this is my last *Journal* article, I would like to express my very deep appreciation for the courtesies you have extended to me as auxiliary president. My year as president has been a privilege and a pleasure. It has been gratifying to have had the opportunity to meet and to get to know so many of your wives—they are select, knowledgeable and truly wonderful people! I sincerely hope that through their efforts and mine, something of substantial value has been contributed to the ISMA, the general public, the future of American medicine and to the future of our country.

Bea Shields



# Butazolidin®
**brand of phenylbutazone**

# in rheumatoid arthritis

**Geigy**

**Therapeutic effects**
A number of workers have reported major improvement in 50-75% of cases, with some successful cases going into complete remission.

In responsive cases, improvement is generally seen within a week, so that trial therapy need seldom be continued beyond this period. Alleviation of pain is followed quickly by improvement of function and resolution of effusion or other signs of active inflammation. Relief of arthritic symptoms is quite frequently accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

**Precautions**
Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

**Side effects**
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

**Contraindications**
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

*Note:* The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

**Butazolidin® alka**

| Each capsule contains: | |
|---|---|
| phenylbutazone | 100 mg. |
| dried aluminum hydroxide gel | 100 mg. |
| magnesium trisilicate | 150 mg. |
| homatropine methylbromide | 1.25 mg. |

**Butazolidin® brand of phenylbutazone**
Tablets of 100 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York
BU-3479

# Review of Bills in Which ISMA had an Interest

## MEDICAL PRACTICE

*S.B. 53—Now known as Chapter 123* **(will become effective on proclamation).**

An act to permit physicians to secure a temporary medical teaching permit to teach in medical educational institutions in this state.

This law permits physicians not licensed in the state of Indiana to procure from the State Board of Medical Registration and Examination, in their discretion, a permit to teach medicine in such an institution for a period not to exceed one year.

It provides that said physician shall register with the state medical board and that the institution shall file application with the board certifying to the professional qualifications and the term of the teaching appointment, along with the medical subjects to be taught and such other information as the board may require. On approval, the board will issue a medical teaching permit which shall be kept by the institution and surrendered to the board for cancellation within 30 days after the person has ceased his teaching responsibilities.

The permit will authorize the holder to perform in the institution only such acts of medicine, surgery and obstetrics as are usually and customarily performed by a teaching physician.

## PUBLIC HEALTH

*S.B. 128—Now known as Chapter 358* **(will become effective on proclamation).**

This amends the Public Health Code of 1949 primarily by adding new sections.

This amendment provides for the establishment of full-time county health departments or multiple county health departments and provides for the submission of budgets to the county council and for the employment by the health officers of all personnel. The mayors of each city shall appoint one member in the proportion of the city's population as it relates to total county population. If more than one major city is in the county, the appointment shall be made first by the mayor of the largest city. The board of county commissioners shall appoint the remaining members of the board.

The terms of appointment shall be for four years and the board shall consist of seven members, at least two of whom must hold an unlimited license to practice medicine in the state of Indiana. The board shall be made up of not more than a majority of one from the same political party. A county board of health will appoint the health officer who shall be the executive officer for the department and shall serve as the secretary of the board. The law also provides that the county council shall levy taxes annually to support such department. The law further provides that second class cities with a population of 100,000 or more may have a city board of health.

## MEDICAL RECORDS

*S.B. 153—Now known as Chapter 148* **(will become effective on proclamation).**

An act concerning medical records, information and data to promote and facilitate medical studies, research and education.

This provides for physicians, hospitals, sanitariums, nursing or rest homes, or other similar organizations or institutions to furnish to the state health commissioner, or his health representative, information which can be used in medical studies of conditions causing death or disability, especially stillbirth, infant and maternal mortality and exempts such informants from any action for damages or other relief.

Such information as received by the state health commissioner shall be kept confidential and is to be used solely for the purpose of medical or scientific research and medical education or the improvement of the quality of medical care. It empowers the health commissioner to furnish this information to medical schools and medical staff committees but such information supplied

shall not disclose the identity of the patients whose records have been included in such information.

It provides further that these studies may be released by the health commissioner for general publication for the purpose of advancing medical research, medical educa- and in the interest of reducing morbidity or mortality. In all instances, the identity of any person studied shall be confidential and privileged and shall not be revealed.

## NARCOTICS

*S.B. 158—Now known as Chapter 392* **(will become effective on proclamation).**

An act defining and relating to narcotic drugs.

This bill provides for dispensing or selling within a period of 48 consecutive hours any product with more than four (4) grains of opium, or more than one-half (½) grain of morphine or any of its salts, or more than four (4) grains of codeine or any of its salts, or with more than one of each preparation.

The following may be dispensed so long as no more than any one of the preparations may be sold in the same preparation within a period of 48 consecutive hours, any medicinal preparation that contains in one (1) fluid ounce, or if a solid or semi-solid preparation, in one (1) avoirdupois ounce, not more than two (2) grains of opium, not more than one-quarter (¼) of a grain of morphine or any of its salts, not more than one (1) grain of codeine or any of its salts.

Any person found in possession of any more of the drugs than above enumerated, such findings should be prima facie evidence of violation of the provisions of this law. The law further provides that nothing shall prohibit a manufacturer or wholesaler from selling any quantity of the above drugs nor prohibit a duly licensed physician, veterinarian or dentist from prescribing, administering or dispensing any quantity of such drugs. It further does not prohibit a pharmacist from dispensing larger quantities upon prescription when said use is for medical purposes only and not for the satisfaction of an addiction.

It empowers the State Board of Pharmacy by regulation to make certain exemptions. Those found guilty of violations shall be deemed guilty of a felony and upon conviction in the first offense, may be fined not to exceed $1,000.00 and may be sentenced for an indeterminate period of not less than one year and not more than five years. For conviction of a second offense, such person may be fined no more than $2,000.00 and may be sentenced for an indeterminate period of not less than five years nor more than 15 years. For a third conviction, they shall be fined no more than $5,000.00 and be sentenced for an indeterminate period of not less than ten years and no more than 25 years.

## MEDICAL PRACTICE

*S.B. 284—Now chapter 156* **(now in effect under emergency clause).**

An act to permit persons to take graduate training in medicine in medical educational institutions or hospitals in this state by registering with the State Board of Medical Registration and Examination for an internship and for obtaining a temporary medical permit from the board to obtain such graduate training other than an intern.

This law permits any person who has completed academic requirements for graduation from a medical school located within the United States, its possessions, or in the Dominion of Canada, desiring to obtain graduate medical education or training by serving an internship or residency in a medical educational institution or with a hospital located within the state. In the case of an intern, the applicant shall register with the State Board of Medical Registration together with credentials showing completion of the academic requirements of a school meeting the requirements of the Indiana State Board and official verification of such applicant's appointment for internship. When approved, an internship registration will be issued which will authorize the performance of such medical acts as are usually and customarily performed. It further provides that the educational institution having such a person enrolled for internship shall within 30 days after the acceptance and appointment of such person notify the medical board of this fact giving the person's name, place of residence, and name of the medical school in which such person has completed the aca-

demic requirements, listing the type of medical education or training to be taken by such person.

Also it provides that the institution shall notify the medical board in writing within 30 days after such person has completed or discontinued such training. Failure to do so will disqualify the institution from further participation in the benefits of this act. There shall be no charge for this.

*Residencies.* A person desiring to take a residency in this state shall, upon application to the medical board, receive a temporary medical permit. Ostensibly the same information must be provided the board as for an internship and when approved a temporary medical permit will be issued for an original fee of $10.00. Annual renewals thereafter are $5.00 and may be renewed annually at the discretion of the board. Before renewal, the institution in which the person is taking the graduate training shall supply the board a written report from said institution certifying to the applicant's satisfactory service, stating whether such service has been terminated and, if not terminated, that the appointment has been extended and the term of the extension thereof. As of the last day for which the temporary medical permit was issued, it provides that it shall automatically expire and the said permit shall be surrendered to the board. A person violating this act will be judged guilty of a misdemeanor and fined no less than $25.00 nor more than $200.00.

## MINOR CONSENT FOR SURGERY

*S.B. 324—Now known as Chapter 158* **(now in effect under emergency clause).**

An act concerning medical and hospital care and treatment of married and emancipated minors and their children.

This law authorizes a person under age of 21 who is married and living with his or her spouse, or who has been emancipated, to give consent to and contract for medical or hospital care or treatment of himself or herself including surgery, and when parents of a child and under 21, they are authorized to give consent and to contract for medical, surgical and hospital care or treatment of such child.

## MEDICAL PRACTICE

*S.B. 359—Now Chapter 159* **(now in effect).**

An act concerning qualifications for applicants for certificates to practice medicine issued by the Board of Medical Registration and Examination of Indiana.

This provides that physicians who have graduated from foreign medical schools may be granted a license to practice medicine in Indiana by reciprocity or endorsement if he was otherwise eligible other than the fact that he was a graduate of a foreign medical school if such registrant has completed a minimum of two years of postgraduate training in this country and has completed three years of active practice in the state in which he was licensed.

The act also provides that any person licensed by any state and who would be entitled to receive a license to practice medicine, surgery and obstetrics in Indiana by reciprocity or endorsement, except the state issuing such license granted the license upon an examinaton by a medical examining board other than the board of said state, such as a national examination board, shall be entitled to receive licensure in Indiana by reciprocity or endorsement.

## KERR-MILLS

*H.B. 1155—Now Chapter 309* **(will become effective Jan. 1, 1966).**

Amends an act concerning medical assistance for the aged.

This law amends the free choice section of the Kerr-Mills Act, inserts the word chiropractors and provides for free choice of hospitals, including private hospitals. Such hospital may not charge more than a state or municipal hospital or more than a charge for which a county department of public welfare can obtain such care and services at a local county tax-supported hospital facility.

## COURT SUMMONS

*H.B. 1277—Now known as Chapter 53* **(will become effective on promulgation).**

An act which amends section 263 of the 1881 act concerning proceedings in civil cases.

This provides that any person may be subpoenaed as a witness for a hearing or

trial to be held any place within the state and attendance will thereby be required. It also provides for taking interrogatories providing they shall be signed by the person making them. It provides a complete, fully answered copy to be in the hands of the courts within 15 days after service and provides for ten days for filing of objections.

It is the opinion of Robert Hollowell, ISMA counsel, that this bill does not repeal Sec. 292 of said act of 1881, which latter section provides that the attendance of physicians, attorneys, state and county officers, or a judge cannot be enforced in a county in which the witness does not reside. Our counsel has conferred with the attorney who wrote said bill, and said attorney is of the same opinion.

### REPORTING PKU TESTS

*H.B. 1302—Now Chapter 81* **(will become effective on promulgation).**

An act in relation to the disease of phenylketonuria.

This law provides that the State Board of Health shall institute and carry on an intensive educational program among physicians, hospitals, public health nurses and the public concerning the disease and other inborn errors of metabolism. The program shall include information about the nature of these diseases and examinations for the detection of the diseases. It provides the State Board of Health shall, with the advice of medical authorities, determine and request appropriate tests to be used in the detection of this disease.

It empowers the State Board of Health and local boards of health to encourage and promote plans and procedures for the detection of this disease in all newborns.

It provides that the board of health shall provide forms on which shall be noted the result of the tests performed on each child and the report shall be sent to the board of health by physicians and hospitals. It permits the board of health to promulgate rules and regulations for implementation of the *intent* of the act. Parents of infants may object in writing for reasons pertaining to religious beliefs only.

### KERR-MILLS

*H.B. 1351—Now Chapter 94* **(will become effective on promulgation).**

An act to amend the law concerning medical assistance for the aged.

This law amends the Kerr-Mills Act to remove the prior requirement that dental, chiropractic and optometric services be certified as necessary by a physician. It retains the requirement that other services in medical institutions shall be performed only upon certification by a licensed physician except in the case of an emergency.

### EXEMPTS DRUGS FROM SALES TAX

*H.B. 1140—now Chapter 232* **(now in effect).**

This is a rather long bill, consisting of thirty-one (31) printed pages amending the sales tax provisions of the gross income tax law as adopted by the 1963 General Assembly. The parts particularly applicable to the practice of medicine are the following:

1. Sec. 6 (a) amends Sec. 37 as added in 1963. This excepts sales to doctors, dentists, etc. of "drugs of the type which may be sold only upon a prescription, insulin, oxygen, blood or blood plasma, when such items are to be directly consumed in professional use . . . ."

2. Sec. 7 amends Sec. 39 as added in 1963. This is the section excluding transactions. Subsection (b) (13) is as follows:

> "Sales of drugs dispensed by a registered pharmacist upon the order of a practitioner licensed to prescribe, dispense, and administer drugs to human beings in the course of his professional practice, and sales of drugs by such a licensed practitioner; sales of insulin; sales of oxygen, blood or blood plasma when sold for medical use."

The effects of the above amendments are to remove from the effect of the sales tax law all drugs sold or dispensed by a physician, whether or not they are prescription drugs. Also excluded are all sales of drugs by registered pharmacists sold on prescription, whether or not the prescription involves a prescription drug. Sales by pharmacists of a nonprescriptive drug, without a prescription, are subject to tax.

Purchases of drugs by a physician from a retail merchant are exempt as to prescription drugs, but not as to the other drugs.

Druggists or pharmacists would be classified as retail merchants. However, purchases of drugs from a wholesaler would be exempt whether or not the drugs purchased be prescription drugs, for the reason that wholesale sales are not subject to the sales tax.

## REPORTING CHILD ABUSE

*H.B. 1176—now Chapter 268* **(now in effect).**

This bill provides for reporting by physicians and other persons of certain physical abuse of children under sixteen (16) years of age. There is, to some extent, a conflict between Section 1 and Sec. 2 of the bill, Section 1 stating that physicians, interns, residents, laboratory technicians, nurses, pharmacists, chiropractors or other persons furnishing medical aid who become aware of such cases (children who have had physical injury inflicted upon them) *should* report them to the county department of public welfare or the law enforcement agency having jurisdiction.

Sec. 2 provides that any physician, osteopath, or chiropractor who, upon examining, treating or caring for a child under the age of sixteen (16) years "determines by medical diagnosis and findings that the child has had physical injury or injuries inflicted upon him other than by accidental means by a parent or other person responsible for his care, *shall* report this act." It is then provided that when the attendance of a physician with respect to a child is pursuant to the performance of services as a member of a staff of a hospital or similar institution, he shall notify the person in charge of the institution who shall report or cause reports to be made.

Sec. 3 provides that an oral report *shall* be immediately made by telephone or otherwise, and followed by a report in writing to the county department of public welfare or the law enforcement agency having jurisdiction. Such report shall contain the names and addresses of the child and his parents or other person responsible for his care, if known, the child's age, the nature and extent of the child's injuries including any evidence of previous injuries, and any other information that the physician believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator. It is provided that forms for such reports shall be provided by the county department of public welfare.

Sec. 4 provides that the Department of Public Welfare shall cause an investigation and upon completion, if the facts warrant, submit a written report to the prosecutor.

Provision then is made in Sec. 5, Sec. 6 and Sec. 7 that anyone participating in good faith in the making of such report or in a judicial proceeding resulting herefrom, shall have immunity from liability either civil or criminal, including immunity from liability for the disclosure of matters which might be considered confidential because of the doctor-patient relationship. It is also provided that the physician-patient privilege shall not be grounds for excluding evidence in any judicial proceeding. ◄

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# Maternal Mortality Study Committee Report of 1962 Maternal Deaths*

INDIANA had 108,700 births in 1962. Maternal deaths for 1962 totaled 37 for a maternal mortality rate of 3.4 deaths per 10,000 live births.**

The committee reviewed a total of 52 deaths which occurred in 1962 and in which the women were either pregnant at the time of their death or had been pregnant within the past year. Of the 52 deaths studied, 47 were determined to be related to pregnancy and were, therefore, regarded as maternal deaths.

As to the actual causes of death in these 47 maternal deaths, 13 (28%) were due to hemorrhage, 12 (26%) were due to infection, three (6%) were due to toxemia of pregnancy, two (4%) were due to amniotic fluid embolism, three (6%) were due to pulmonary embolism, four (9%) were anesthetic deaths and six (12%) were from cardiovascular disease. Uremia, pneumonitis and uncontrolled diabetes were the cause of one death each. A definite cause could not be determined in one case. Table I shows the number and causes of death.

The cause of the hemorrhage was ruptured ectopic pregnancy in five cases, ruptured uterus in two cases, post-partum hemorrhage in three cases, abruptio placenta in one case, placenta previa in one case and hemorrhage from undetermined causes in one case.

Infection accounted for twelve deaths. Septicemia resulting from self-induced or criminal abortion caused five deaths. Surgical infection was associated in two deaths and septicemia occurring several days after rupture of the membranes prior to delivery of the fetus caused three deaths. The portal of entry of infection was unknown in two instances.

Table II shows the number of deaths by age group and Table III by parity.

As to prenatal care, 12 patients had none, five sought care in the third trimester, four in the second trimester, 18 in the first trimester and it was unknown in eight cases whether there was prenatal care or not.

Thirty-three of the women were white; 14 were of other races. Autopsies were performed in 30 of the cases.

Table IV shows the result of pregnancies with reference to the infant.

### Summary

Hemorrhage is again the most frequent cause of death. Five of the 13 deaths from hemorrhage were, however, ruptured extra-uterine pregnancies. Five of the 12 deaths from infection were associated with abortion. Complications of anesthesia accounted for more deaths (4) than pregnancy toxemia. Eclampsia was the cause of death in only two instances and pregnancy toxemia in a previously hypertensive patient resulted in one death from cerebral hemorrhage.

Twenty-eight of the 47 patients were under 30 and 10 died during their first pregnancy. Only 18 of all the patients had prenatal care beginning in the first trimester and 17 had either received no prenatal care or it began only in the third trimester.

Of the 29 delivered patients who died, 12 were delivered by Cesarean section, an incidence of 42%. The deaths were the result of infection in three, toxemia in three, anesthesia in three, hemorrhage in two and in one instance, uncontrolled diabetes. Ten of the 12 infants were born alive, one with cerebral palsy, so one can assume the patients were not in precarious condition at the time the Cesarean was performed.

* The sixth report of the Maternal Mortality Study Committee of the Indiana State Medical Association.

** Indiana State Board of Health reports.

NUMBER AND CAUSES OF DEATH

| Cause | Number of Cases | | | Percent |
|---|---|---|---|---|
| | Under 30 | 30 & over | Total | |
| Hemorrhage | 6 | 7 | 13 | 28 |
| Infection | 10 | 2 | 12 | 26 |
| Toxemia | 2 | 1 | 3 | 6 |
| Anesthesia | 1 | 3 | 4 | 9 |
| Amniotic fluid embolism | 1 | 1 | 2 | 4 |
| Pulmonary embolism | 2 | 1 | 3 | 6 |
| Cardiovascular disease | 2 | 4 | 6 | 12 |
| Other | 4 | 0 | 4 | 9 |
| | | | 47 | 100% |

TABLE I

DEATHS BY AGE

| Age of Mother | No. of Deaths |
|---|---|
| Under 20 | 1 |
| 20 - 24 | 18 |
| 25 - 29 | 9 |
| 30 - 34 | 12 |
| 35 - 39 | 6 |
| 40 or over | 1 |

TABLE II

NUMBER OF DEATHS BY PARITY

| No. of Pregnancies | No. of Deaths |
|---|---|
| 3 and under | 22 |
| 4 and over | 23 |
| Unknown | 2 |

TABLE III

FETAL OUTCOME

Lived more than 24 hours - 19
(1 set of twins)

| | | |
|---|---|---|
| Under 5½ lbs. | 1 | |
| Over 5½ lbs. | 17 | (1 set) |
| Weight not recorded | 1 | |

Stillborn or lived less than 24 hours - 11

| | |
|---|---|
| | 4 |
| | 2 |
| | 5 |

Not delivered - - - 18
1st trimester - 7
2nd trimester - 9
3rd trimester - 2
Term - 0

TABLE IV

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*Medicine At Law*

# DECISIONS AND OPINIONS

**Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.**

*Evidence Sufficient to Support Grand Jury Indictments for Failure to Furnish Medical Attendance and Shelter to Baby*— There was sufficient evidence before a grand jury to support an indictment of the mother of a baby, who died about four weeks after birth, for failure to furnish medical attendance, and an indictment against its father for failure to furnish it with shelter, a New York trial court ruled.

When the mother noticed, about ten days before the baby's death, that she had a diaper rash, she treated it with home remedies. Although the rash became progressively worse until her death, the baby was never treated by a doctor for the condition.

Doctors who examined the baby shortly after her death described the rash condition, in testifying before the grand jury, in such language as, "dirty matter which appeared full of sores and boils," "nth degree of diaper rash," "the entire area was congested and covered with real ulcers" and "an eczemic state of ulceration."

The mother told the grand jury about the home remedies she used in treating the rash. She testified that she had not taken the baby to the doctor because she was due for her four weeks checkup within a few days, that the doctor was already owed a lot of money and that she did not know when or how the bill could be paid. There was also testimony that the baby's father had not worked for three weeks before her death and that the family's financial condition was bad.

The statute making the willful failure to furnish a minor child with medical attendance a misdemeanor does not require that a doctor be called for every trifling ailment with which a child may be afflicted, the court said. The standard is whether an ordinary prudent person, solicitous for his child's welfare and anxious to promote its recovery, would deem it necessary to call in the services of a doctor.

It was the function of the grand jury to determine whether all of the legal evidence before it would warrant a conviction by a trial jury. The grand jury's indictment of the mother was valid only if the evidence as a whole was the equivalent of prima facie proof that she had committed the crime charged. The evidence here constituted the necessary prima facie proof, the court ruled.

There was no evidence before the grand jury that the father knew about the baby's rash. Therefore, he could not be charged with willfully failing to furnish her with medical attendance.

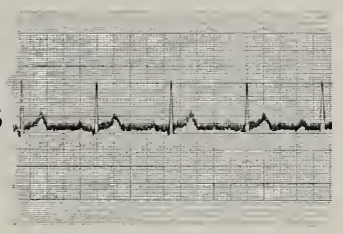
The father was also charged with willfully failing to furnish the baby with shelter. There was evidence before the grand jury that at a time when the baby was present there was no heat in the house and it was very cold. Furnishing shelter, as used in the statute, includes not only providing a structure in which the child may live but also includes the duty to see to it that there are no conditions in the structure which are or may be injurious to the child's health and welfare. There was prima facie proof that the father willfully failed to furnish the baby with shelter, the court ruled.

*People of the State of New York v. Edwards,* 249 N.Y.S.2d 325 (N.Y., May 8, 1964).

*Operation Ordered for Comatose Patient*

Continued

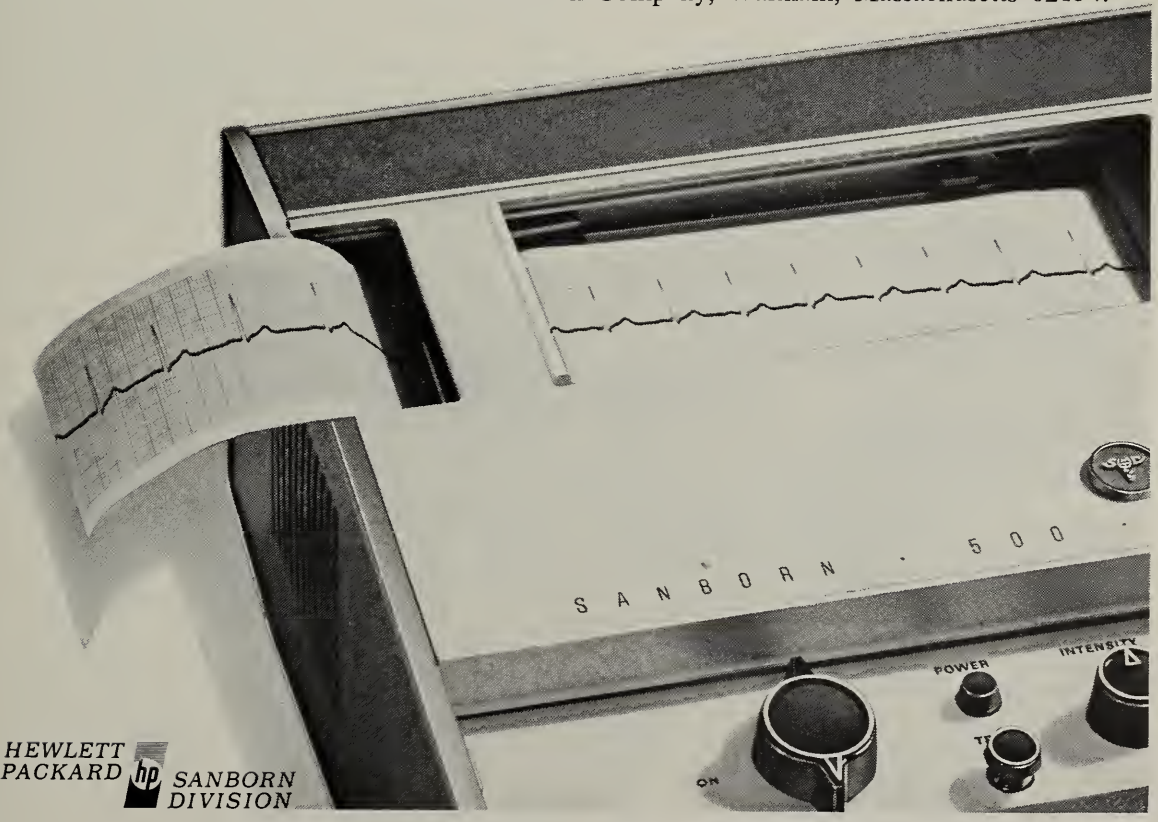
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Continued

*Whose Wife Refused Consent*—A superintendent of a county hospital was entitled to an order permitting an operation to be performed on a comatose patient whose wife had refused to give her consent, where the evidence showed that the patient would die if the operation were not performed, but that if it were performed he would have a good chance to live, a New York trial court ruled. Once the patient came to the hospital seeking medical attention, it became the responsibility of the hospital and its doctors to treat him. Without the consent, the doctors had the choice of performing the operation or letting the patient die. It could not reasonably be said that the comatose patient and his wife should or could put the hospital and the doctors to this impossible choice.

*Collins v. Davis,* 254 N.Y.S.2d 666 (N.Y., Dec. 4, 1964).

*Privilege Against Self-incrimination not Violated by Admission of Blood-alcohol Tests in Evidence*—The admission in evidence, in a prosecution against a driver on a charge of first-degree manslaughter growing out of a collision, of the results of blood-alcohol tests administered to the driver did not constitute a violation of his privilege against self-incrimination, where there was sufficient evidence to establish that the driver had consented to the tests, an Oklahoma intermediate appellate court ruled.

The privilege against self-incrimination protects an accused not only from testimonial compulsion but also from being forced to furnish evidence by means other than by word of mouth. Therefore, the admission in evidence of the results of blood tests, drunkometer tests, etc., which are taken involuntarily would constitute a violation of the privilege against self-incrimination.

The driver contended that he was unable to consent because of a concussion which he received in the accident. An osteopath stated his opinion, on the basis of an examination he made of the driver three days after the accident, that he would have been suffering from a concussion after the accident to such an extent that he would have been unable to consent. A policeman who went from the scene of the accident to the hospital with the driver testified that, although the driver was intoxicated, he was not incoherent and displayed no abnormality of any sort. It was not an abuse of discretion on the trial court's part to determine from this evidence that the driver consented to the tests and to deny his motion to suppress the test results.

The driver also contended that the test results should not have been admitted in evidence because he was not under arrest when the tests were administered and the results were, therefore, the fruits of an illegal search and seizure. In view of its position that the constitutional right involved was the privilege against self-incrimination, it was not necessary to consider this contention, the court said.

The issue of whether the driver consented to the tests was submitted to the jury under appropriate instructions. Even if it could be said that the test results should not have been admitted in evidence, there was suf-


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ficient testimony by police and others who were at the scene of the accident or the hospital that the driver was intoxicated to sustain his conviction, the court said.

*Cox v. State of Oklahoma,* 395 P2d 954 (Okla., July 8, 1964; rehearing denied, Sept. 23, 1964; second petition for rehearing denied, Nov. 10, 1964).

**Citation Editor's Note:** Most courts have held that the privilege against self-incrimination is limited to testimonial compulsion. ◄

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# Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
Indianapolis

### Rheumatic Heart Disease

A puzzling problem that frequently confronts the physician who is following a patient with rheumatic heart disease is whether the risk of systemic emboli is great enough to warrant long term anticoagulant therapy. Szekely[1] reports on the experience of 5,832 patient-years dealing with this group of patients. The predominant vascular lesion in these 754 patients was mitral stenosis. The group was divided into an anticoagulant treated group and a control group. It was found that the incidence of embolism was seven times higher in patients with atrial fibrillation than in the group with a normal sinus rhythm. The study showed rather clearly that anticoagulants had a protective effect against embolic phenomena. Recurrences of embolization were 2½ times more frequent in the control group than in the anticoagulant group. The author also states that mitral valvulotomy would not eliminate the danger of embolism and that it was even questionable whether it reduced the incidence of this complication. He feels that long-term anticoagulant therapy should be given to patients with both sinus rhythm and with atrial fibrillation and that this therapy is an effective method of reducing emboli.

### Vacuum Extraction

Although occasional reports regarding the vacuum extraction as a help in delivery have appeared in journals in this country, most of the favorable reports have appeared in literature outside the United States. The present report[2] deals with the use of this device in 400 deliveries in Worcester during the period from 1948 through 1963. The author states that fetal mortality has fallen progressively during this time and that this has been accompanied by a decrease in the incidence of forceps delivery and Caesarean section. The instrument used in the present report is the Malmstrom extractor. The principal indication for the use of the instrument has been uterine inertia with prolongation of the second stage of labor. Fetal distress has been the second most common indication for its use and a variety of other conditions are outlined in the report. The present report includes the use of the extractor in four cases of breech presentation. The author feels that the vacuum extractor offers greater safety for both mother and child. He states that the present method has much to offer and has encouraged its further use in other institutions.

### Status Asthmaticus

A report by El-Shaboury, et al.,[3] records their findings of elevated S.G.O.T. levels in 40% of patients suffering from status asthmaticus. The authors had no clear-cut reason for this finding since it seemed unlikely that impaired hepatic function could account for the rise. None of the 60 patients in the study had evidence of myocardial infarction and liver function studies were generally non-diagnostic. The significance of this finding, of course, is applied clinically in attempting to differentiate patients with acute pulmonary edema secondary to coronary occlusion and patients with status asthmaticus. Failure to recognize this fact could lead to the erroneous diagnosis of coronary occlusion.

### Edema and Rheumatoid Arthritis

Patients with rheumatoid arthritis have been known for many years to have edema of the feet and ankles. The mechanism by which this edema is produced is not well known. The present report[4] gives the observations on 40 patients with this clinical condition and analysis of the fluid in 18 of these cases. The edema was found to be low protein in nature and it would not seem to bear any relationship to the serum protein level. The author determined that the edema

was not dependent on the presence of varicose veins or thrombophlebitis. Through a number of vascular studies, the author concludes that this edema should be regarded as a clinical feature of rheumatoid arthritis and that it is likely due to altered venous function which is manifested primarily in the very small veins.

### S-T, T Wave Changes

The cryptic phrase "non-specific S-T, T wave changes" has troubled clinicians for many years. It has been well known that exertion, emotional stress, climate, indigestion and a number of other factors will all influence the S-T segment and the T waves in normal people. It is also puzzling to try to tell whether these changes may be due to digitalis therapy or to underlying heart disease. The authors[5] ran a clinical study on ten healthy medical student volunteers and after digitalization, one-half of the volunteers were given two grams of ascorbic acid. The authors demonstrated that the ascorbic acid therapy restored upright T waves in the cardiograms on these healthy patients. This effect was not noted on patients who had abnormal electrocardiograms and underlying heart disease. There was no effect from the ascorbic acid on any manifestation or digitalis toxicity as had been reported previously. None of the controls showed alteration of their EKG after absorbic acid.

### Dysphagia, Anemia and Glossitis

Dysphagia, anemia and glossitis are usually known in this country as Plummer-Vinson syndrome; however, the present report deals with the same syndrome only under another name.[6] The authors studied 55 cases of this condition and found that the the anemia seen in this condition was probably due to a variety of causes rather than simple iron deficiency anemia as is usually considered. Iron deficiency was discovered but so was achlorhydria and subnormal vitamin B-12 absorption. The authors feel that this condition may be genetically determined and that the gastric atrophy which they observed led to impaired vitamin B-12 absorption as the primary mechanism. They feel that the iron deficiency part of the anemia is very likely a secondary feature. Future studies will be needed on this condition; however, this report seems well documented and should cause an increased interest in this condition by other observers.

### The Neurotic Patient

Giel, et al.,[7] have recorded their observations on a group of patients who are usually passed over as rapidly as possible in clinical practice. This study deals with a follow-up on 100 neurotic patients who manifested a wide variety of clinical neuroses. A symptomatic breakdown on the patients is reported and some general conclusions are drawn as to their prognosis. The authors do not go into great detail as to the type of therapy used; however, they state that 71% of the patients were improved after five years. They found a definite relationship showing that the longer the duration of illness, the poorer the prognosis could be expected. A history of previous psychiatric illness in female patients, but surprisingly enough not in males, was shown clearly to be of bad prognostic importance. This high recovery rate seems at variance with the experience of most clinicians and it raises the question as to whether the patients merely appeared to be improved at a time when they were "between neuroses."

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7. Giel, R., Knox, R. S., Carstairs, G. M.: A Five-year Follow-up of 100 Neurotic Out-patients, *Brit. Med. J.* 5402:160-163. ◄

# 1964 Record Year for Indiana Health Care Plans

*(One of a series prepared by Blue Shield)*

1964 was a year of record-breaking growth for Indiana Blue Shield, with new highs established in membership totals, the number receiving benefits and payments made to members and physicians. Year-end figures also revealed that it was the best year ever in terms of low-cost operating efficiency.

Blue Shield enrollment reached 1,520,148 as of December 31, 1964. This represented a net gain of 28,321 for the year.

A total of $25,846,611 was paid for members' doctor bills during the year. The comparable 1963 amount was $23,319,855.

The number of claims paid in 1964 was 727,020, as compared to the 1963 figure of 662,710.

Income from membership fees totaled $27,694,075; 1963 fee income was $25,224,030.

Held in reserve at year end for members' future health care needs was $7,753,495—or $5.10 per member. During 1964 our surplus situation improved, showing a gain of $75,787.

Indiana Blue Shield since organization in 1946 has now paid to members for physicians' services a grand total of more than 190 million dollars.

Our operating expense in 1964 was the lowest ever, amounting to 6.6% of income.

Indiana Blue Cross also reported 1964 as a record year. A total of $66,517,721 was paid out for 358,643 hospital cases. Of this total, 126,264 were outpatient cases not requiring bed care. Blue Cross membership was 1,591,835 at year end.

In 1964 the Blue Shield program of selling broader benefit plans to new accounts and converting present accounts to programs matching medical practice today continued to show substantial gains.

At the end of the year, 927,290 members were enrolled under the preferred or special programs. That is 61% of our membership and represents a net gain of 74,149 for the year.

Blue Shield preferred or special in-hospital medical programs now protect 772,404 members or 51% of total membership. The net gain for the year was 20,081.

The enrollment division continued to stress the sale of a wide range of diagnostic x-ray and pathology endorsements, and as of December 31, 1964, 64% of our account membership had diagnostic benefit protection. The net gain for the year was 76,795.

At the end of 1964, some 265,000 members were covered by programs based on the Indiana State Medical Association's county schedule resolution #26. Considering the number of members protected by these programs, there have been very few complaints and this cooperative effort continues to be a success.

Since organization—Blue Cross in 1944 and Blue Shield in 1946—the two Indiana health care plans have paid out a grand total of more than 696 million dollars in helping the people of Indiana solve their own health care financing problems. ◄

W. C. Huddlestone
Public Relations Division



Dollars Today—
—Doctors Tomorrow
American Medical Association
Education and Research Foundation
535 North Dearborn Street, Chicago 10, Illinois

AMA-ERF

# Stelazine® brand of trifluoperazine will calm your anxious working patient—with little or no drowsiness

When anxiety interferes with work, your patient needs a drug that will calm without causing undue drowsiness. With Stelazine (trifluoperazine, SK&F), you can promptly control the anxiety without producing the sedation seen with certain other agents. Anxious patients can remain active during therapy.



Stoll[1] used the drug in 50 patients with anxiety, and noted: "There was no drowsiness in this group of patients and, because of their alertness and less impaired concentration, they were able to continue with and, in some cases, return to their daily work."

Stelazine (trifluoperazine, SK&F) produces a fast therapeutic response—often within 24 to 48 hours. The convenient b.i.d. regimen frees patients from the need for a midday dose.

*Principal side effects,* usually dose-related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness, amenorrhea and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been rare. Use with caution in patients with impaired cardiovascular systems. *Contraindicated* in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage.

Before prescribing, see SK&F Product Prescribing Information.

Photograph professionally posed.

1. Stoll, L. J.: The Use of Trifluoperazine ['Stelazine'] in General Practice, M. Press *243*:578 (June 29) 1960.

SK&F **Smith Kline & French Laboratories, Philadelphia**

# ABSTRACTS

# BOOK REVIEWS

## CONTROL OF GLYCOGEN METABOLISM* AETIOLOGY OF DIABETES MELLITUS AND ITS COMPLICATIONS**

* Ciba Foundation Symposium, July, 1963, Little, Brown & Co., Boston, Mass.; 434 pages, numerous illustrations, $12.50.

* * Ciba Foundation Symposium, October, 1963, Little, Brown & Co., Boston, Mass.; 405 pages, illustrated, $12.50.

It has been said that we are living in the revolutionary period of the transformation of medicine from an empiric qualitative *art* to a quantitative, biochemical, macromolecular *science*. The two closely related symposia, held almost at the same time, exemplify this aphorism most aptly.

At the turn of the 20th century, Dr. Starling was coining the word, hormone (chemical messenger) as a term to express the basic concept of the science of endocrinology which he was helping to found. Adrenaline was isolated in 1901. Insulin was discovered in 1921. (One of its revealers, Dr. C. H. Best, is still very much alive and active in *research*.) Enzymes were just beginning to be known. Mitochondria, ribosomes, nucleic DNA and such were still awaiting the investigative tools which were to reveal their presence. The hypophysis, adrenals and thymus were largely terra incognita. Doctors practicing as late as the years just before World War II were being very up to date if they used adrenalin, insulin and a crude extract of the posterior hypophysis (for its oxytocic effect) in their practices. Adrenalin was the only hormone whose exact chemical structure was known.

The two symposia being reviewed are a measure of the enormous distance biochemistry has traveled; it is also a measure of the colossal discoveries trembling on the brink of revelation. The very first page of the volume on "Glycogen" presents us the basic structural formula of glycogen in Figure 1 as elucidated by Meyer in 1943. The steric configuration is used to summarize, briefly, the already known facts as to the probable reasons of the WHY various specific enzymes act as they do. Only then do the experts launch into an animated analysis of the continuing clarification of the precise metabolic processes involved in the still confusing interplay of the chains of enzymes mediating glycogenesis and glycogenolysis. Just what stimulates ATP formation and degradation? Where does glucagon come in? What does the autonomic system have to do from microsecond to microsecond? Hexokinase and glucokinase: what are their chemical structures? How do we relate glycogen storage diseases (numbers one through five)


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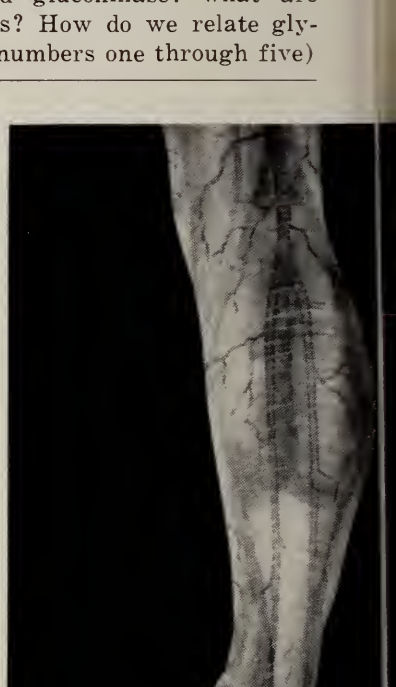
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IN CEREBROVASCULAR INSUFFICIENCY

leading to such symptoms as mental confusion, diplopia, vertigo and lightheadedness.



IN PERIPHERAL VASCULAR DISEASES

where ischemia causes pain, spasm, ache, intermittent claudication; also coldness, numbness or ulcera of extremities.

to them? We had eponyms such as von Gierke's, Pompe's and McArdle's diseases; now we are graduating to more specific terminology as amylopectinosis, limit dextrinosis and other terms outlining the specific enzymic lesion. How soon will the specific genome lesion be known?

Similarly, the symposium on "Diabetes" accepts and surmounts the challenges that are presented. In great and constructive detail, we are led to the very frontiers of present day knowledge concerning insulin, its synthesis in the laboratory, its biosynthesis in the pancreas itself, its interactions with such antagonists as glucagon and the pituitary polypeptides . . . . This volume is a "must" for every serious student of medicine in general and diabetes in particular.

Medical school sophomores are being taught material unknown a mere couple of decades ago. Yet these two symposia will be completely out of date a couple of decades hence. For the immediate present, there is nothing quite the equal of these works: pithy, precise and completely authoritative. As usual, the printing is excellent, the binding and paper superb; typographical errors are conspicuous by their absence. The bibliographies are exhaustive. The Ciba Foundation can again be congratulated on a difficult task well done. The general practitioner will find this rewarding reading; the specialist will come to these monographs again and again.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

## THE HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES

Adolph G. DeSanctis, M.D. and Charles Varga, M.D., C. V. Mosby Co., St. Louis, 438 pages, plus index.

This handbook is now available in its third edition. And just in time. The previous edition of this valuable compendium is no doubt well-worn and ragged wherever it was available to physicians caring for children. Its publishers, the C. V. Mosby Company, are evidently aware of this heavy use, since the third edition is prepared with better and stronger paper and the new cover should prove more flexible and durable.

The format remains the same. The types of emergency are listed and described according to the nature of the physiologic disturbance or to the organ system involved. Two new chapters, for example, detail the emergency care of neonatal and psychiatric problems. Few pediatric maladies of any significance are not considered in this book, and the emergency treatments recommended are lucid, practical, and generally accepted technics. The index is complete and the type very legible. A very useful appendix provides a formidable array of common poisons, many useful dosages and normal values and even an accident prevention fact sheet for physicians and parents. After most chapters, the bibliography is comprehensive and current.

Drs. DeSanctis and Varga have invited nine




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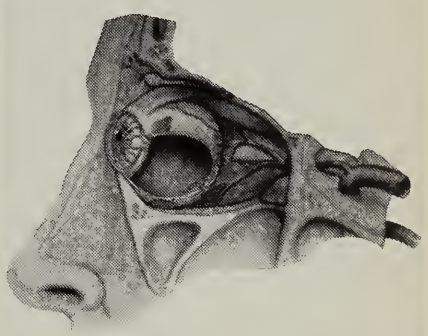
where decreased blood flow results in hearing loss (sudden onset), tinnitus, or vertigo.

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decreases resistance in arteries and arterioles in skeletal muscle, in the brain, and possibly in the eye and inner ear • increases cardiac output (minute stroke volume) • maintains mean arterial blood pressure • enhances blood flow in ischemic tissues • well tolerated, with rapid and sustained response • economical

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in which vasospasm and impaired circulation are factors.

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other contributors to collaborate with them in this third edition, yet all chapters are similarly arranged in the tradition of prior editions. A helpful listing of subheadings introduces each chapter and most information is presented in the familiar outline form. This makes for quick recognition at the risk of over-simplification. Hans George Keitel, M.D. could not be so constrained in his treatment of Metabolic Emergencies (Chapter 2) and the result is a rephrasing of his scholarly treatise, *Pathophysiology and Treatment of Body Fluid Disturbances*, New York, 1962, Appleton-Century-Crofts. His choice for calculation of requirements and dosages is in milligrams and milliliters per kilogram of body weight and that method of computation is continued fairly consistently throughout the other chapters. Calculation in terms of surface area is mentioned but briefly, and many may mourn the absence of the familiar nomogram allowing rapid translation from the one method to the other. Instead, a comparison of three sample weights and areas is provided in the appendix.

For the most part, cross references among the various chapters are well labeled, and the division of labor between any two discussions of the same problem is nicely drawn. Few errors, typographic or grammatical, were encountered. A propensity of the authors to favor brand names over their generic counterparts is at times disturbing and certainly inconsistent, but can be defended, I suppose, as being conducive to clarity and easy recognition. Certain pronouncements are perhaps overstated; i.e., in Chapter 11, "Eye Injuries"—"under no circumstances should anyone who is not an ophthalmologist employ an eye medication containing corticosteroid." This warning is then compromised by the listing of "corticosteroid-antibiotic ointment" as suggested therapy in "chemical burns" and again in "welding and electric arc flash burns of the eye."

The popular chapter which lists, explains and demonstrates with photographs many "Pediatric Procedures" has been retained and will continue to prove most useful.

Also very helpful are the 95 pages devoted to poisoning. Any worthwhile attack on the tremendous problem of childhood poisoning must be an herculean effort, since the diversity of possible noxious compounds and their management methods defy logical schemes of condensation and tabulation. The assembled material is largely very accurate, but certain omissions are difficult to understand. For example, the near inevitability of pneumonia after significant hydrocarbon ingestion is not mentioned. Another valuable addition would be the inclusion of some expectation information about each compound. Too frequently, the physician responsible for therapy of a poisoned child is unable to determine the actual toxic dose of the poison in question. He is then armed with many methods—some mild and some extreme—which he may use unnecessarily for inconsequential doses of potentially toxic substances. There are perhaps too few data defining minimal toxic dosages and

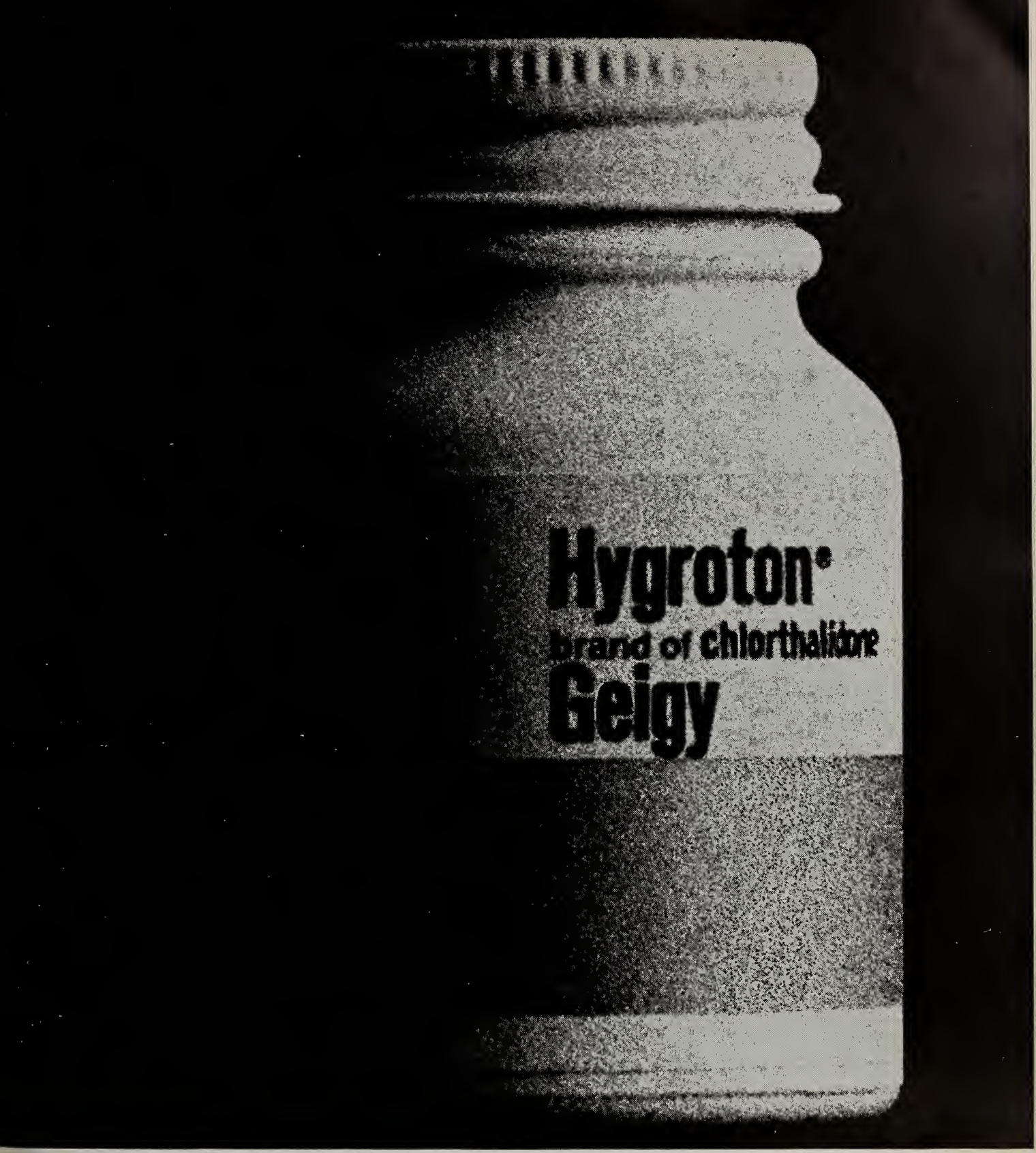
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Indications: Many types of edema involving retention of salt and water.
Contraindications: Hypersensitivity and most cases of severe renal or hepatic disease.
Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
Average Dosage: One tablet (100 mg.) daily with breakfast.
Availability: Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

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**Hygroton®**
**brand of chlorthalidone**

**The long-acting diuretic**




# ho needs it?

Patients with edema.
Edema in congestive heart failure.
Or in the premenstrual syndrome.
Edema in pregnancy...or obesity.
Patients you want to bring to dry weight.
And those you want to keep at dry weight.
Those you want on single daily doses.
And those requiring even fewer doses.
Those resistant to other therapy.
And those intolerant of other diuretics.
Those who have to pinch pennies.

Continued

probable fatal dosages. Nevertheless, one hopes that future editions of this and other guides on management of poisonings will provide such information.

A careful reading of the third edition of the *Handbook of Pediatric Medical Emergencies* only serves to emphasize the importance of this volume to all physicians who undertake the care of children. Its prominent and handy place in every pediatric department and emergency room will continue to be well deserved.

THOMAS J. CONWAY, M.D.
Terre Haute

## Abstracts From Various Literature, Prepared by AMA

### MALIGNANT LYMPHOMA IN SURVIVORS OF THE ATOMIC BOMB IN HIROSHIMA

R. E. Anderson (Atomic Bomb Casualty Commission, Hijiyama Park, Hiroshima, Japan) and Kenzo Ishida

*Ann. Intern. Med.* 61:853-862, (Nov.), 1964.

This report concerns 91 cases of unequivocal malignant lymphoma diagnosed by lymph node biopsy or autopsy at the Atomic Bomb Casualty Commission (ABCC), Hiroshima, Japan, during the period 1949 to 1962 inclusive. An increased prevalence of Hodgkin's disease, lymphosarcoma and multiple myeloma is found in this sample among proximally exposed survivors of the atomic bomb explosion of August 6, 1945. A consideration of the epidemiological features of the autopsy and surgical case material supports the view that this increase in prevalence is a reflection of the occurrence of lymphoma in the general population of individuals exposed within 1,400 meters of the hypocenter. The occurrence of reticulum cell sarcoma is apparently decreased in this same group of survivors; the reasons for this seeming paradox are obscure. Although the prevalence of lymphoma is increased in persons exposed to ionizing radiation autopsied at ABCC, there is no known method for identifying an individual case as radiation-induced.

### CANCER RISK IN ULCERATIVE COLITIS

I. P. M. MacDougall (Gordon Hosp., Vauxhall Bridge Rd., London)

*Lancet* 2:655, (Sept. 26), 1964.

The results of a follow-up, for from one to 15 years, of 637 patients with ulcerative colitis, free from detectable bowel cancer, are reviewed. The incidence of bowel cancer in these patients was compared with the expected incidence for a population of this age and sex structure. Patients with colitis of only a part of the colon had no special cancer risk; cancer incidence in total colitis was 30 times the expected figure and colectomy with retention of the rectum did not reduce this figure. Prophylactic colectomy was contraindicated therefore in distal colitis, but was recommended in total colitis together with rectal excision in colitis of the whole colon of more than 10 years' duration.

### DISCOLORATION OF PRIMARY DENTITION AFTER MATERNAL TETRACYCLINE INGESTION IN PREGNANCY

J. N. Swallow (Dental School, 17 Newport Rd., Cardiff, Wales)

*Lancet* 2:611, (Sept. 19), 1964.

A child, whose mother had subacute myeloblastic monocytic leukemia during pregnancy and was given large doses of tetracycline in addition to other drugs, had yellow staining of the primary dentition.

### TWO CASES OF CHRONIC MYELOID LEUKEMIA WITH PRESUMABLY IDENTICAL 47-CHROMOSOME CELL-LINES IN THE BLOOD

B. Pedersen (University Institute of Human Genetics, Copenhagen, Denmark)

*Acta Path. Microbiol. Scand.* 61:497-502 (No. 4), 1964.

Chromosome analysis on cultured leukocytes from two young men with chronic myeloid leukemia has demonstrated an abnormal $Ph^1$-positive cell-line with 47 chromosomes in either case. The karyotypes of both lines lacked a small, submetacentric member of the 17—18 group and contained two supernumerary chromosomes of the 6—X—12 group. ◄

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## to help relieve pain in common anorectal disorders

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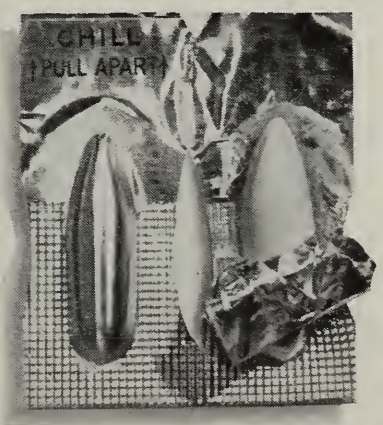
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

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liperodon 1.0%; oxyquinoline enzoate 0.1% in a special ointnent base.

NDICATIONS:
Provides temporary palliation of pain that may result from hemorhoidectomy and from common norectal disorders such as hemorhoids, anal fissures, pruritus ani.




**DIOTHANE SUPPOSITORIES**

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
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**AMERICAN MEDICAL ASSOCIATION CONVENTION**
Date June 20-24, 1965
Place New York, N. Y.

**AMERICAN COLLEGE OF SURGEONS, INDIANA CHAPTER**
Date May 2-5, 1965
Place Aboard the Delta Queen Riverboat, leaving from Cincinnati, O.

**BONE AND JOINT CLUB**
Date April 14, 1965
Place The Athenaeum, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 19, 1965
Place Indianapolis

**INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS**
Date May 15, 1965
Place Indianapolis Athletic Club

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 12-14, 1965
Place Murat Temple, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

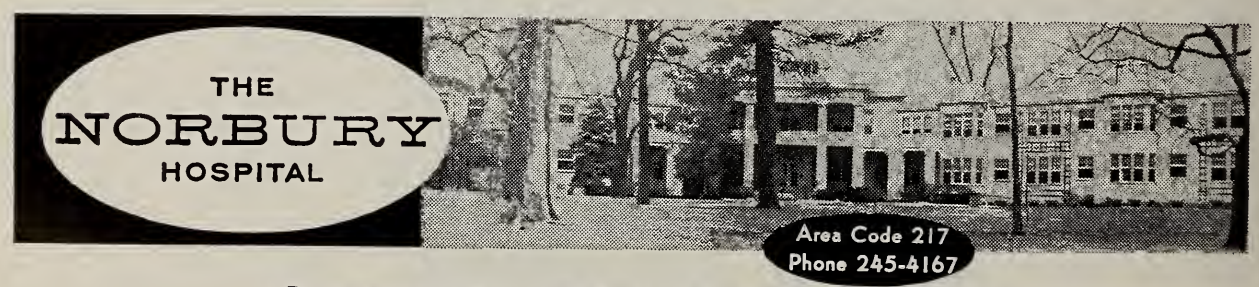
**INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**
Date May 7-8, 1965
Place Oakbrook, Ill.

**INDIANA ORTHOPAEDIC SOCIETY**
Date June 25-26, 1965
Place Marott Hotel, Indianapolis

**INDIANA CHAPTER of the AMERICAN ACADEMY OF PEDIATRICS**
Date April 21-22, 1965
Place Marott Hotel, Indianapolis

**INDIANA ROENTGEN SOCIETY**
Date May, 1965
Place Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


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Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

*LICENSED:* Illinois Department of Mental Health.
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**convenient**—no refrigeration or other storage precautions
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Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

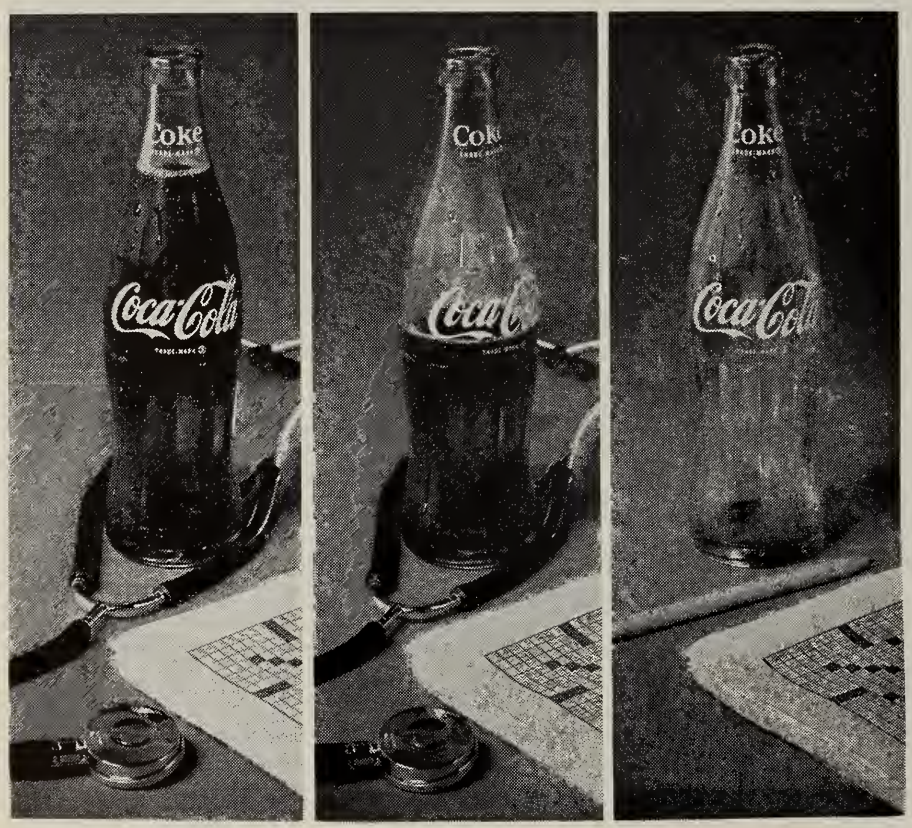
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# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—February, 1965

| Disease | Feb. 1965 | Jan. 1965 | Dec. 1964 | Feb. 1964 | Feb. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 329 | 283 | 403 | 396 | 293 |
| Chickenpox | 743 | 890 | 766 | 608 | 1054 |
| Conjunctivitis | 116 | 139 | 123 | 139 | 86 |
| Diphtheria | 0 | 1 | 0 | 0 | 1 |
| Dysentery, Unspecified | 29 | 42 | 99 | 204 | 219 |
| Gonorrhea | 267 | 319 | 349 | 333 | Not Available |
| Impetigo | 100 | 103 | 133 | 130 | 96 |
| Infectious Hepatitis | 70 | 29 | 38 | 46 | 163 |
| Infectious Mononucleosis | 94 | 40 | 63 | 62 | 44 |
| Influenza | 1301 | 612 | 820 | 1060 | 12591 |
| Measles (Rubeola-Rubella) | 320 | 209 | 188 | 2054 | 686 |
| Meningitis, Meningococcal | 4 | 5 | 5 | 5 | 3 |
| Meningitis, Other | 9 | 3 | 8 | 7 | 5 |
| Mumps | 335 | 324 | 652 | 843 | 408 |
| Pertussis | 32 | 28 | 33 | 16 | 63 |
| Pneumonia | 299 | 291 | 261 | 226 | 316 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 0 |
| Streptococcal Infection | 753 | 577 | 611 | 647 | 993 |
| Syphilis | | | | | |
| Primary & Secondary | 9 | 3 | 5 | 3 | Not Available |
| All Other Syphilis | 80 | 90 | 84 | 103 | Not Available |
| Tinea Capitis | 9 | 30 | 45 | 21 | 10 |
| Tuberculosis (Active) | 87 | 86 | 81 | 78 | 85 |


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Prolixin is a dependable tranquilizer that provides your patient with low cost therapy. No other tranquilizer costs less. Safe and convenient for office use—Prolixin in a single daily dose provides prolonged and sustained action. Markedly low in toxicity and virtually free from usual sedative effects —Prolixin is indicated for patients who must be alert. Clinical experience indicates fluphenazine hydrochloride is especially effective in controlling the symptoms of anxiety and tension complicating somatic disorders such as premenstrual tension, menopause, or hypertension—also useful for anxiety and tension due to environmental or emotional stress. When you prescribe Prolixin you offer your patient effective tranquilization that is low in cost, low in dosage and low in sedative activity.

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**SIDE EFFECTS, PRECAUTIONS, CONTRAINDICATIONS:** As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photo-sensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders.

**AVAILABLE:** 1 mg. tablets. Bottles of 50 and 500.

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SQUIBB Squibb Quality—the Priceless Ingredient

SQUIBB DIVISION Olin




## DR. APPEL, AMA PRESIDENT-ELECT TO SPEAK AT I.U. ALUMNI DAY

James Z. Appel, M.D. of Lancaster, Pennsylvania, president-elect of the American Medical Association, will be the speaker at the annual Alumni Day of the School of Medicine Alumni Association on the Medical Center campus on Wednesday, May 12, 1965.

Class reunions are also being scheduled in connection with the event for the classes of 1915, 1920, 1925, 1930, 1935, 1940, 1945, 1950, 1955 and 1960. All alumni are invited to attend the events and reservations may be sent to Alumni Reservations, Medical Science Building, Room 163, Indiana University Medical Center, Indianapolis.

The School of Medicine Alumni Association has chartered a Circle Line excursion boat during the American Medical Association meetings in New York on Wednesday, June 23rd. The four-hour cruise will cover the New York City waterfront, the Statue of Liberty and a cruise up the Hudson. Dinner will be served aboard ship.

### *PMA Issues Free Catalogue Listing Publications for Laymen*

Public education in health is facilitated by use of the booklets, charts and pamphlets published by the ethical pharmaceutical industry.

The Pharmaceutical Manufacturers Association, which represents the makers of over 90% of U. S. prescription drugs, has issued a free catalogue listing over 130 small publications suitable for laymen. Subjects covered include disease prevention, mitigation and cure; drug discovery, development and manufacture; educational helps, health careers and biographies of drug makers. These are intended to help reporters, teachers, students and others as a source of information on health.

There is also a catalogue available listing 169 moving picture films on health which are available on a free loan basis. To obtain the catalogues write the Association at 1155 15th St., N. W., Washington, D. C. 20005.

### Dr. Dill Honored by Goodwill

Dr. Myron K. Dill, Indianapolis, is the recipient of the Indianapolis Goodwill Industries' 1965 Rehabilitation Award, made "for outstanding development of a medical program for sheltered workshops."

Dr. Dill was Medical Director for Goodwill from 1955 to 1964 and upgraded the medical evaluation and medical supervision programs for the physically disabled. He also developed Goodwill's educational program for student and graduate nurses. His Goodwill work is being studied for adoption by other Goodwill's and similar workshops for the handicapped.

### *American College of Ob-Gyn Publishes Second Edition*

The "Manual of Standards in Obstetric-Gynecologic Practice," published by the American College of Ob-Gyn, will appear soon in its second edition. It consists of a compilation of recommendations for proper patient care.

The new edition is more comprehensive than the first and three times greater in volume. It will be distributed gratis to all Fellows of the College and may be obtained by non-fellows, for $2.50, by writing the College at 79 W. Monroe St., Chicago 60603.

### Indiana Pathologists Named Diplomates

Seven Indiana physicians have been certified as Diplomates of the American Board of Pathology.

They are: Merritt O. Alcorn, M.D., Kings Daughters Hospital, Madison; Isabelle A. Buehl, M.D., Indiana Univ. Medical Center, Indianapolis; Thomas A. Randall, M.D., Indiana Univ. Medical Center, Indianapolis; James J. Sullivan, M.D., St. Vincent's Hospital, Indianapolis; Glenn B. Mather, M.D., Bloomington Hospital, Bloomington; Suzanne M. Paulsen, M.D., Terre Haute and Emmanuel Psomatakis, M.D., St. Margaret Hospital, Hammond-East Chicago.

### *Assistants Wanting Certification Asked to Contact Headquarters*

The American Association of Medical Assistants announces that assistants who are interested in studying for the 1966 certification examination can obtain detailed study outline and bibliography on request from AAMA's headquarters, 510 N. Dearborn St., Chicago 60610.

### Pitman-Moore Appointments

The Pitman-Moore Division of Dow Chemical

Continued




# *a result of 'METHEDRINE'® brand METHAMPHETAMINE HYDROCHLORIDE therapy

Her once unruly appetite is now well tamed with 'Methedrine' (methamphetamine hydrochloride)...an easy way to help control food craving and "hunger pains."

**Side effects:** Insomnia may occur if taken later than 6 hours before retiring. The usual peripheral actions of sympathomimetic amines (vasoconstriction and acceleration of the heart) are minimal and little noticed on low or moderate dosage.

Complete literature available on request from Professional Services Dept. PML.

**Contraindications and precautions:** Should not be used in patients with myocardial degeneration, coronary disease, marked hypertension, hyperthyroidism, insomnia or a sensitivity to ephedrine-like drugs. Moderate hypertension in the obese is not necessarily a contraindication since it may be relieved as the overweight is reduced.

'Methedrine' brand Methamphetamine Hydrochloride: Tablets–5 mg., scored, in bottles of 100 and 1000.

**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.**

has named Charles V. Flemming, a native of South Bend, as Scientific Assistant to the Director of Pharmaceutical Laboratories; and has named Dr. Bill J. Munden, a native of Seymour, as Head of Pharmaceutical Product Development.

## *American Geriatrics Society Announces Lederle Grants*

The American Geriatrics Society today announced the renewal of three $1,800 grants to stimulate more extensive study of the medical problems of the aging by resident physicians.

Known as the Lederle Residency Supplements, the grants will be used to augment the salaries of residents interested in geriatrics while they continue their medical education.

Funds are donated by Lederle Laboratories, Division of American Cyanamid Company, to cover the period, July, 1965 to June, 1966.

Application for the Lederle Residency Supplements should be addressed to the Chairman, Fellowship Committee, American Geriatrics Society, 10 Columbus Circle, New York 19, New York. Deadline for applications is May 1, 1965.

## Book for Teenagers

Doubleday is publishing a book "Way to Womanhood" by Dr. W. W. Bauer and his wife, Florence Marvyne Bauer, intended for instruction of teenage girls in the physical and emotional changes of puberty.

Dr. Bauer is Director Emeritus of the AMA Department of Health Education.

## *Blood Volume Determination Film Available for Meetings*

A medical motion picture explaining why determination of blood volume is important and demonstrating how to determine blood volume by use of a new electronic device called "Volemetron" is available through the Ames Company.

The film runs for 25 minutes in sound and color and may be obtained for medical meetings without charge by writing the Ames Film Department at Elkhart, Indiana.

## Capt. Johnson Decorated

Captain Russell J. Johnson, MC, of Gary was decorated with the Bronze Star for aiding the wounded at Qui Nhon, South Vietnam, after a billet was blown up during a Viet Cong attack.

## *Intravenous Cholangiography Film Now Available to Physicians*

A medical motion picture on intravenous cholangiography is made available by E. R. Squibb & Sons.

The film is 16 mm., and runs for 20 minutes with sound and color. It is available for medical meetings, free of charge, from all Squibb regional offices or by writing Squibb at 745 Fifth Ave., New York City.

## Dr. Buchanan Named President

Dr. Wallace D. Buchanan, South Bend, was recently installed as president of the American College of Radiology at its annual meeting in Philadelphia. Dr. Buchanan has just completed a term as chairman of the College's Board of Chancellors.

## *American Society of Oral Surgeons Announces Manuscript Awards*

The American Society of Oral Surgeons wishes to announce that two cash awards (first prize $300.00—second prize $200.00) will be presented at the 47th annual meeting in Denver, November 2-6. These awards will be for superior, original, unpublished manuscripts concerning any phase of research related to oral surgery completed during the current year.

Individuals interested in these competitive awards should write to the American Society of Oral Surgeons, 919 North Michigan Ave., Chicago 11, for further information.

## Dr. Wood Speaker on Eldercare

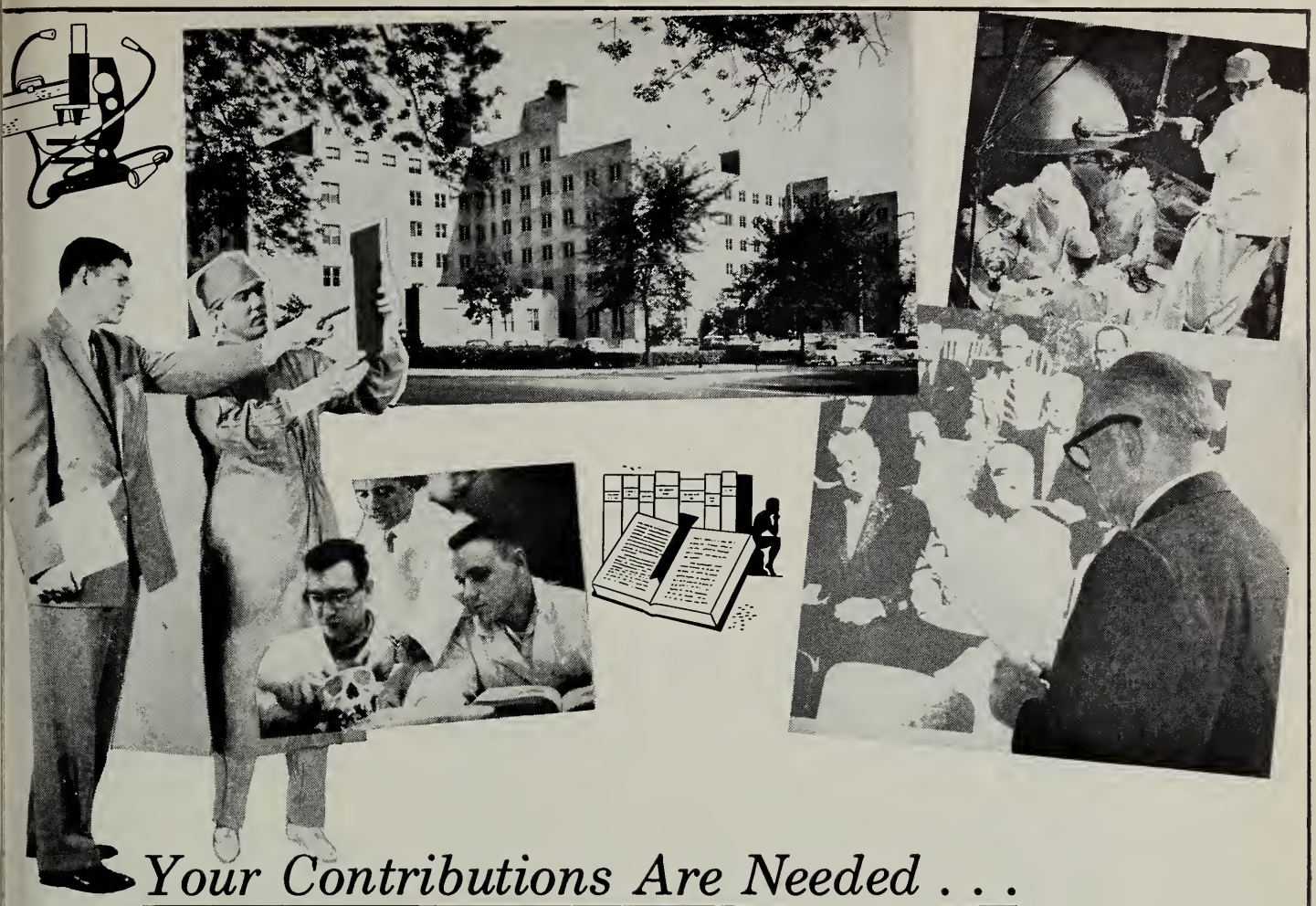
Dr. Donald Wood, former president of the Indiana State Medical Association, spoke on Eldercare at a forum in Wichita, Kansas in February.

The forum was sponsored by the Sedgwick County Medical Society and the *Wichita Eagle and Beacon*. Dr. Wood appeared as a spokesman for the AMA; Sen. James Pearson, (R., Kan.) discussed Medicare and Dr. D. Cramer Reed, Wichita urologist, explained the differences between the two bills.

## *Strict Tax Regulations Issued For Professional Corporations*

The Internal Revenue Service has finally issued its amended regulations for professional service organizations. There is little change in the final version from the proposed regulations issued in 1963.

The regulations seem to offer little hope that the laws adopted by several states authorizing professional corporations will be effective in qualifying members of such corporations for tax-deferred retirement benefits. The standards require that a professional service organization match the major characteristics ordinarily found in business corporations to qualify for the tax benefits. ◄



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# SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans $12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.

AMA-ERF

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**Education and Research Foundation**
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# FUTURE MEETINGS, SEMINARS, COURSES

## Indiana Public Health Association Schedules 19th Annual Conference

The Indiana Public Health Association will conduct its 19th annual conference on April 28 and 29 at the Severin Hotel in Indianapolis. Four hundred public health workers are expected to attend.

Kenneth W. Bush, administrative assistant of ISMA will be moderator for the first general session on the subject "Impressions of Public Health." Gale E. Coons, executive director of the Indiana State Dental Association will moderate a panel on "Evaluate the Impressions."

A third general session will consist of a seminar on Salmonellosis with Dr. Daniel Bernoske, director of the Lake County Health Department, as chairman. Several section meetings and special interest sessions are scheduled.

## *North Shore Hospital Lists Spring, 1965, Lecture Series*

North Shore Hospital announces its spring, 1965 Lecture Series, sponsored by the Lakeside Laboratories, Inc., to be held at the North Shore Hospital, 225 Sheridan Road, Winnetka, Illinois.

The program will consist of the following:

April 28: *Office Management of Emotional Problems in Adolescents*, Marvin Schwartz, M.D., Formerly Chief of Child Psychiatry, Presbyterian-St. Luke's Hospital, Chicago, Illinois.

May 26: *Office And Home Management of Psychiatric Emergencies*, Beverly Mead, M.D., Chairman, Department of Psychiatry, Creighton University, Omaha, Nebraska.

All members of the medical profession are invited to attend these lectures free of charge. Meetings will start at 8:00 p.m. Refreshments will be served.

## Pediatric Postgraduate Course Offered in Colorado in August

A pediatric postgraduate course, covering clinical and research advances in pediatrics and child guidance, will be held by the University of of Colorado School of Medicine at Estes Park, Colorado, August 2 to 6.

The tuition fee is $75.00. For registration or further details write Office of Postgraduate Medical Education, 4200 E. Ninth Ave., Denver 80220.

## *Aerospace Medical Association 36th Annual Scientific Meeting*

The 36th Annual Scientific Meeting of the Aerospace Medical Association will be held in New York City at the New York Hilton Hotel on April 26 to 29, under the presidency of General T. C. Bedwell of the U. S. Air Force.

Dr. Neal E. Baxter of Bloomington is president-elect of the Association. Dr. Baxter is also co-chairman of the Section on Clinical Aviation Medicine III. Dr. Stuart Bondurant, Indianapolis, is chairman of the Section on Acceleration II; Dr. Dan L. Urschel, Mentone, is chairman of the Section on Clinical Aviation IV.

## World Medical Association To Meet in London in September

The World Medical Association will meet in London from September 19 to 25. The Association has grown tremendously since it last met in London in 1949 in its fourth year of existence.

The six-day meeting will be complete with a scientific program oriented around "Communicable Diseases and Modern Travel." Social events are planned for all and a special ladies program has been arranged. Information on observer credentials, accommodations, individual and group travel, medical tours and sightseeing is available from the United States Committee, WMA, 10 Columbus Circle, New York City 10019.

## *SMA Section of Ophthalmology Schedules November Meeting*

The Section of Ophthalmology of the Southern Medical Association will meet in Houston, Texas on November 1 to 4, 1965.

Papers are being accepted from now until May 15. A title and brief abstract should be sent to Dr. George S. Ellis, 812 Maison Blanche Bldg., New Orleans 70116.

## American Cancer Society's Scientific Session to be in June

"Hormones and Chemotherapy for Cancer—A Critical Appraisal" will be the theme for the 1965 scientific session of the American Cancer Society to be held at the Drake Hotel in Philadelphia, June 16.

Members of ISMA are invited to attend. There is no registration fee. For further information write the society at 219 E. 42nd St., New York City 10017.

## *Continuing Education Course on Neuromuscular Diseases of Children*

The Cook County Graduate School of Medicine announces a two-week intensive continuing education course in the Neuromuscular Diseases of Children, with special emphasis on management, to be given by Dr. Meyer A. Perlstein for the period of June 7-18. This is an intensive didactic and clinical course designed for pediatricians, orthopedists, neurologists, psychiatrists and physiatrists interested in the care and treatment of children

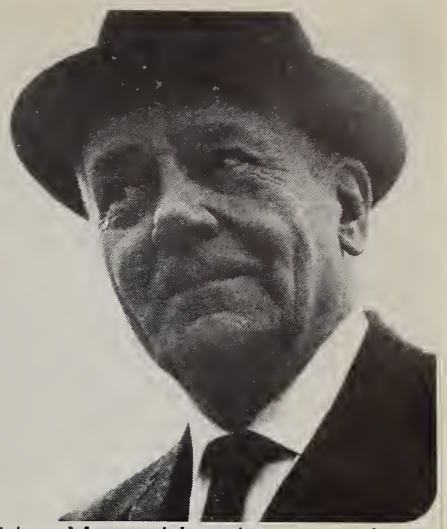
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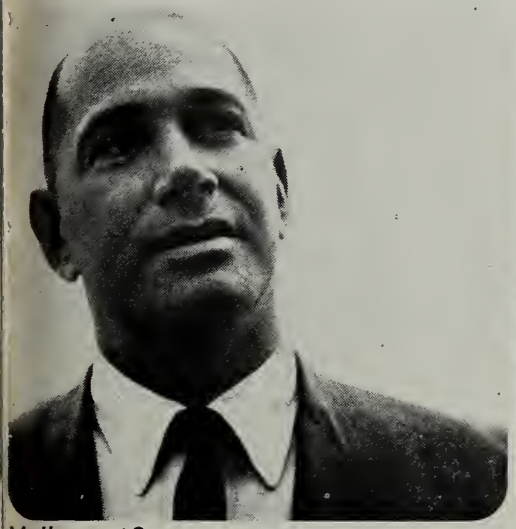
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*Warning:* Discontinue 2 weeks before general anesthesia, 1 week before electroshock therapy, and if depression or peptic ulcer occurs.
*Precautions:* Reduce dosage of concomitant antihypertensive agents by one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
*Side Effects:* Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

*Average Dosage:* One tablet daily with breakfast.
*Availability:* Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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with neuromuscular handicaps.

Emphasis will be placed on the practical clinical aspects of treatment and rehabilitation procedures. The course will include trips to demonstration clinics and treatment centers. Fee for the course is $290, and since registration will be limited, applications should be made as far in advance as possible. For further information, write to the Registrar, Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612.

## *American Ob-Gyn Board Schedules Part II Exams*

The Part II (oral and clinical examination) for all scheduled candidates will be conducted by the entire board at the Edgewater Beach Hotel, Chicago, Illinois, April 26-May 1.

New and reopened applications and requests for re-examination in the Part II examination for 1966 will be accepted in the office of the secretary during April and May. Applications and requests postmarked later than May 31st will be returned to the sender. CANDIDATES ARE REMINDED THAT DUPLICATE LISTS OF PATIENTS DISMISSED FROM THEIR SERVICE DURING THE TWELVE MONTHS IMMEDIATELY PRECEDING APRIL 1, 1965 MUST ACCOMPANY APPLICATION OR REQUEST TO TAKE THE PART II EXAMINATION.

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Current bulletins outlining present requirements, and application forms may be obtained by writing to the office of the secretary, Clyde L. Randall, M.D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

## Postgraduate Gastroenterology Course Listed for October 28, 29 and 30

The annual course in postgraduate gastroenterology of the American College of Gastroenterology will be given at the Americana Hotel in Bal Harbour, Fla., on the 28, 29 and 30 of October.

The moderators for the course will again be Dr. I. Snapper, Director of Medical Education, Brookdale Hospital Center, Brooklyn, N. Y. and Dr. John L. Madden, Clinical Professor of Surgery, New York Medical College and Director of Surgery, St. Clare's Hospital, New York, N. Y. For further information and enrollment, write to the American College of Gastroenterology, 33 W. 60th St., New York, N. Y. 10023.

## *Joint Meeting Planned by Ear, Eye Nose and Throat Organizations*

The Central Illinois Eye, Ear, Nose and Throat Society and the Indiana Academy of Ophthalmology and Otolaryngology will hold a joint meeting on Friday and Saturday, May 7-8, at the new Drake Oakbrook resort at Oakbrook, Illinois just 15 miles west of Chicago. An interesting and enjoyable program has been arranged, and all physicians are invited to attend.

Guest speakers will be: Ophthalmology, Dr. Donald J. Lyle, Cincinnati and Dr. Harold G. Scheie, Philadelphia; Otolaryngology, Dr. Herbert B. Goldman, Rockville Centre, N. Y. and Dr. Linden J. Wallner, Chicago.

## The American Fracture Association Lists Dates of Future Meetings

The American Fracture Association cordially invites all physicians who are interested in various types of fracture treatment to attend the annual meeting to be held at the Riviera Hotel in Las Vegas, Nevada, October 24 to 28.

The American Fracture Association, whose membership includes physicians from North, Latin and South America, is the only organization which limits its entire programs to the treatment of fractures by various methods.

In 1966 the annual meeting will be held in Caracas, Venezuela, November 1 to 5, and in 1967 will be held at the Sheraton-Chicago Hotel in Chicago, Illinois, October 28 to November 2.

All physicians interested contact Dr. H. W. Wellmerling, Secretary General, 610 Griesheim Building, Bloomington, Ill. ◄



**effects and precautions:** The transitory wsiness which may occur with hydraxyzine usually disappears spontaneously in a few s with continued therapy, or is correctable dosage reduction. Dryness of the mouth may seen with higher doses. Involuntary motor vity has been reported in hospitalized ients on higher than recommended doses. lroxyzine HCl may potentiate CNS depres- ts, narcotics such as meperidine, barbitu- s, and anticoagulants. In conjunctive use, age for these drugs should be decreased. ause drowsiness may occur, patients should cautioned against driving a car or operat- dangeraus machinery. **Parenteral Solution autions and contraindications:** This dosage n is intended only for I.M. or I.V. adminis- ion and shauld not, under any circum- nces, be injected subcutaneausly ar intra- erially. When the usual precautions for I.M. ction have been followed, reports of soft ue reactions have been rare. I.V. adminis- ion should be slow, no faster than 25 mg. minute, and should not exceed 100 mg. in single dose. Particular care should be used nsure injection only into intact veins; a few ances of digital gangrene occurring distal he injection site have been attributed to dvertent intraarterial injection or periarte- extravasation, both of which should be ided. **More detailed professional informa- available on request.**

# WANTED: Locations Physicians

## GENERAL PRACTICE

Edward G. Krug, 142 Merson Dr., Buchanan, Mich. 49107

Lloyd Callaway, Jr., 803 N. Hudson St., Altus, Okla.

John B. Gillen, Jr., 4211 Garibaldi Ave., Jacksonville, Fla. 32210

Patricia A. Campbell, 11 Greenvale Ave., Yonkers, N. Y.—also Internal Medicine

Robert R. Schenck, 825 Fifth St., California, Pa. 15419

James T. Anderson, 1302 Springvale Dr., Apt. 601, San Antonio, Texas

John W. McKinstry, 909 E. Brill St., Phoenix, Ariz. 85006

## SPECIALISTS

Kenneth J. Cichosz, 1898 Twentieth St., Northwest, Rochester, Minn.—*Anesthesiology*

Robert J. Colliton, 220 Park Rd., West Hartford, Conn. 06199—*Anesthesiology*

James L. Striebel, 1463 Beacon St., Brookline, Mass.—*Internal Medicine*

Richard B. Moore, 931 St. Paul Ave., St. Paul 16, Minn.—*Internal Medicine—Cardiology*

James L. Philip, 401 Dickens Dr., Toledo 7, Ohio—*Ob-Gyn*

Walter G. Hertel, 2105 Crimea Rd., Apt. A-2, Baltimore 7, Md.—*Ob-Gyn*

Bruce A. Julien, 122-A Stonewall Dr., Smyrna, Tenn.—*Ob-Gyn*

James E. Weilbaecher, Jr., Charity Hospital, New Orleans, La.—*Orthopedics*

Eli Zonana, 2420 Avenue P, Galveston, Texas 77550—*Pathology*

Paul E. Almeida, 1472 Burmont Rd., Havertown, Pa.—*Pathology*

Walter C. Miller, North Shore Hospital, Manhasset, Long Island, N. Y.—*Pediatrics*

Max Urban, 22120 Moross Rd., Detroit 36, Mich.—*Pediatrics and General Practice*

Walter Zuckerman, U. S. Naval Hospital, Chelsea, Mass. 02150—*General and Traumatic Surgery*

Thomas F. Camp, Jr., 6518 Carrie Lane, San Antonio, Tex. 78218—*General Surgery*

Gottlieb M. Milton, Walson Army Hospital, Ft. Dix, N. J.—*General Surgery*

George M. Shargel, 1800 Tuxedo, Detroit 6, Mich. —*Urology*

Arnold H. Weinstein, Philadelphia General Hospital, Philadelphia 4, Pa.—*Urology*

H. Glenn Gardiner, 3210 Watling St., East Chicago, Ind.—*Industrial and Preventive Medicine*

Charles J. Katz, 3101 N. Van Buren, Wilmington, Del. 19802—*Industrial, Institutional, College and University, Veterans Administration*

Joseph E. Powell, 55 Lakeview Dr., Chetek, Wis.—*General Practice, Industrial, Institutional, College Health* ◄

# County News

## Carroll

Mrs. Lola Parks, director of the Carroll County Department of Public Welfare, spoke on Kerr-Mills and other provisions for indigent medical care at the Feb. 17 meeting of the Carroll County Medical Society.

## Clay

Dr. J. F. Maurer, Brazil, has been elected president of the Clay County Medical Society. Other new officers are: Drs. Donald Garvin, Brazil, vice-president; Forrest R. Buell, Clay City, secretary and Rahim Farid, Brazil, delegate.

## Clinton

Dr. Bruce A. Work discussed a "Plan to Improve Hospital Facilities" with the 15 members of the Clinton County Medical Society present at the Feb. 23 meeting.

## Dubois

Speaker at the Feb. 11 meeting of the Dubois County Medical Society was Dr. John Bretz. His topic was "County Health Problems and the Health Department." The society passed a resolution to urge the Dubois County Commissioners to form a local health department.

## Jackson-Jennings

New officers of the Jackson-Jennings County Medical Society are: Drs. Forrest D. Ellis, president and K. E. Bobb, vice-president and secretary.

## Johnson

Dr. Harry Mock, Jr. has been elected president of the Johnson County Medical Society; Dr. John M. Records, secretary-treasurer; Dr. Joseph Young, delegate and Drs. Charles A. Jones and Joseph Ferrara, alternates.

## LaPorte

Mr. M. Lahey, director of the LaPorte County Welfare Department, spoke on Kerr-Mills Legislation at the Feb. 16 meeting of the LaPorte County Medical Society. Sixty-two members plus 18 dentists and optometrists attended the meeting.

## Marshall

The Marshall County Medical Society have elected the following: Drs. Edward Reno, president; J. Kent Guild, vice-president; Joseph D. Howard, secretary-treasurer; and R. R. Hippensteel, delegate.

## Orange

Dr. Marion L. Hagan has been re-elected president of the Orange County Medical Society. Other officers re-elected were Drs. C. X. McCalla, vice-president and P. T. Hodgin, secretary-treasurer.

Continued

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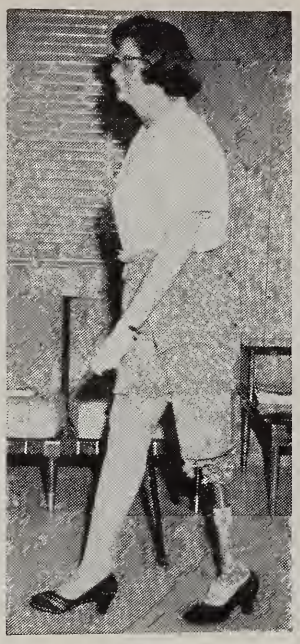
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416 N. Main St., Evansville, Ind. 47711

# COUNTY NEWS

Continued

## Porter

New president of the Porter County Medical Society is Dr. William Robertson, Chesterton. Dr. Thomas Dittmer, Valparaiso is the new vice-president and Dr. Charles G. Griffin, Valparaiso, the new secretary-treasurer.

## Randolph

New officers of the Randolph County Medical Society are: Drs. David J. Landon, president; Harvey White, vice-president; Morris E. McClure, secretary-treasurer and Lowell Painter, delegate.

## Steuben

Dr. Richard Artz, Angola, has been elected president of the Steuben County Medical Society. Assisting him will be Drs. John J. Hartman, Angola, secretary-treasurer and Claude Davis, Angola, vice-president.

## Tipton

The Tipton County Medical Society has elected the following as its new officers: Drs. Raymond Kincaid, president; Robert Haller, vice-president; William A. Kurtz, secretary-treasurer; A. E. Stouder, delegate and B. A. Burkhardt, alternate.

## Wayne-Union

Dr. Charles Echt, of the I. U. Medical Center Ob-Gyn Department, spoke on "Common Gynecological-Endocrinologic Problems" at the Feb. 9 meeting of the Wayne-Union County Medical Society. ◄

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**Side Effects:** Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

**Precautions:** Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

**Formulas:** Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

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**Note:**

The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Ear, nose and throat infections | 507 | 465 |
| Respiratory infections | 1,028 | 954 |
| Gastrointestinal infections | 425 | 387 |
| Genitourinary infections | 748 | 684 |
| Skin and soft-tissue infections | 1,088 | 1,036 |
| Bone and joint infections | 71 | 64 |
| Deep-seated or generalized infections | 257 | 251 |
| Obstetrical & gynecological infections | 341 | 320 |
| Miscellaneous conditions | 592 | 570 |
| Totals | 5,057 | 4,731 (93.5%) |

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# Deaths

### John E. Komoroske, M.D.

Dr. John E. Komoroske, 65, a past president of the Lake County Medical Society, died suddenly Jan. 5 in Tempe, Arizona.

Dr. Komoroske, formerly of East Chicago, had retired to Arizona a little over a year ago after practicing in Lake County for 37 years. A 1926 graduate of the I. U. School of Medicine, Dr. Komoroske had held many offices in the county society and was senior surgeon at St. Catherine and St. Margaret Hospitals.

### John D. Lacy, Jr., M.D.

Dr. John D. Lacy, Jr., Medaryville physician, was found dead in a room at a Lafayette motel Feb. 13. He was 36.

Graduated from the I. U. School of Medicine in 1956, Dr. Lacy was assistant chief of staff at Little Company of Mary Hospital and on the staffs of the Jasper County Hospital at Rensselaer and the Pulaski Memorial Hospital. He was a veteran of World War II and a member of the Pulaski County Medical Society.

### Robert L. Witham, M.D.

Dr. Robert L. Witham, 43, associate of anesthesiology at Community Hospital and a member of its medical staff, died Feb. 3 in the hospital.

Graduated from the I.U. School of Medicine in 1944, Dr. Witham served in World War II and then went into general practice at Culver, from 1946 to 1953. He served his residency in anesthesiology from 1953 to 1955 at the I. U. Medical Center and for a year was anesthesiologist at the Home and St. Elizabeth Hospitals in Lafayette. Since that time he had practiced at Indianapolis. He was a member of the Marion County Medical Society and was certified by the American Board of Anesthesiology.

### James R. Woods, M.D.

Dr. James R. Woods, Greenfield physician for 35 years, died there March 10 at the age of 60.

A native of Grant County, Dr. Woods was a 1926 graduate of the I. U. School of Medicine. He had lived in Greenfield since 1929. He was a veteran of World War II, a member of the Hancock County Medical Society and served on the staffs of Methodist, Hancock County Memorial and W. S. Major Hospitals. ◄

## SCIENTIFIC EXHIBIT APPLICATION FORM

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Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 12-14, 1965, Murat Temple, Indianapolis, Indiana.

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# Association News

## EXECUTIVE COMMITTEE

February 13, 1965

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell, attorney, and J. A. Waggener, executive secretary.

Guests: Mrs. Jack E. Shields, president, and Mrs. H. Carter Dunstone, president-elect, Woman's Auxiliary to the Indiana State Medical Association.

Mrs. Shields and Mrs. Dunstone, representing the Woman's Auxiliary, appeared before the Committee for review of their activities and made a request for the usual allocation of $1,000.00 to assist the auxiliary in carrying out their program. On motion of Drs. Neumann and Rifner $1,000.00 was allocated to the auxiliary.

### Membership Report

| | |
|---|---|
| Number of members as of December 31, 1964 | 4,365 |
| 1965 members as of January 31, 1965 | 2,960* |
| Number of members as of January 31, 1964 | 2,641 |
| Gain over last year | 319 |
| Number of AMA members as of January 31, 1965 | 2,912 |
| Total 1964 AMA members as of January 31, 1964 | 2,586 |
| Gain over last year | 326 |
| 1965 AMA members: Dues paying | 2,463 |
| Exempt, but active | 449 |
| | 2,912 |
| Number who have paid state dues but not AMA dues as of December 31, 1965 | 58 |

* Includes 302 senior and 3 honorary membmers

### Headquarters Office

The secretary reviewed the meeting of the Pharmaceutical Association and gave a status report on this matter for the information of the committee.

### Building Matters

A proposal for lighting the basement from Ermco was presented and the secretary was requested to obtain additional bids for this work.

### Treasurer's Office

The treasurer's report on the financial condition of the association as of January 31, 1965, and on investments of the association, was approved on motion of Drs. Olvey and Larson. By consent it was agreed that the treasurer should sign the authorization for time deposits.

### Annual Convention, October 12-14, 1965, Indianapolis

The preliminary program for the annual convention was reviewed. By consent it was agreed that the Executive Committee meeting on Monday, October 11, 1965, should be held at 10:30 a.m. rather than at 12 noon and that the Council should begin its meeting at 2:00 p.m. rather than at 3:00 p.m.

The committee also reviewed the minutes of the January 24, 1965, meeting of the Commission on Convention Arrangements. The Executive Committee took the position that the Gaslight party should not be limited to physicians and their wives only but that it should be open to physicians and their guests. The committee concurred in the suggestion of the commission that the admission charge be increased to $5.00 per person and recommended that the food be of a lighter nature than that served last year.

Upon motion of Drs. Larson and Olvey, the president is to select the speaker and work out the program for the Thursday noon luncheon, October 14, 1965.

### Legislation:

*National*:

The activity of the AMA was reviewed and the special meeting of the House of Delegates of the AMA held February 6 and 7 was discussed as was the offer of the American Medical Association to allocate $10,622.50 to the state association for conducting a campaign on Eldercare. On motion of Drs. Larson and Neumann, the offer was accepted and the president was authorized to request this amount of money from the American Medical Association.

In discussing an outline for a campaign in Indiana, by consent this was referred to the Council.

*Local*:

The status of bills in the current session of the legislature was reviewed for the information of the committee, as was a letter from Dr. Martin E. Feferman of South Bend.

A letter from Dr. Loren Martin was reviewed and upon motion of Drs. Black and Larson, this is to be referred to the Marion County Medical Society.

### Organization Matters

Plans for the special meeting of the Council were discussed.

A letter from the Indiana State Dental Association to the Blue Shield Plan was read for the information of the committee.

A letter of appreciation from Congressman Halleck concerning the association's recognition of his thirtieth anniversary as a member of the House of Representatives was read for the information of the committee.

A letter from Dr. M. E. Rougraff, chairman of the Medical Relations Committee of the Indiana Health Insurance Council, was reviewed and by consent this was to be referred to the Marion County Medical Society. It was felt that this is a matter for county action and not for action from the state association.

A letter from the Indiana Department of Public Welfare concerning county societies requesting higher fee schedules under the Kerr-Mills program

was referred to the Commission on Governmental Medical Services for its recommendation.

Minutes of the January 12, 1965, meeting of the State Board of Medical Registration and Examination were reviewed for the information of the committee.

A letter from the Indiana Pharmaceutical Association concerning the development of a code of cooperation was reviewed for the information of the committee.

The request of the Indiana Student AMA for the association to renew its sustaining membership in this organization for the sum of $100.00 was approved on motion of Drs. Black and Neumann.

A renewal of the association's membership in the Indiana Conference on Social Welfare in the amount of $15.00 was approved on motion of Drs. Black and Larson.

A letter addressed to the president by Dr. Emmett Lamb as chairman of the Commission on Public Health was read for information and ordered filed.

## The Journal

A letter from the State Journal Advertising Bureau requesting information as to whether the association would accept split runs for advertisers was reviewed and the secretary was instructed to check the cost and to supply this information to the bureau.

## Future Meetings

Medicolegal Symposium, Las Vegas, March 11-13, 1965. On motion of Drs. Neumann and Black, one of the legal counselors was authorized to attend this conference, if he so desires.

There being no further business, the committee adjourned to meet again on Saturday, April 3, 1965, at 3:00 p.m. in the headquarters office.

# COMMERCIAL ANNOUNCEMENTS

AVAILABLE July 1, 1965, well established practice for internist or general practitioner, gross 60,000 yearly. Contact James E. Farner, M.D., 301 W. Fourth St., Mishawaka, Ind.

OUTSTANDING opportunity for physician specializing in internal medicine to be affiliated with well established group in large metropolitan center. Five internists practicing in group. Compensation excellent and no investment necessary. Reply to Box 310, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

GENERAL Practice office for sale; five rooms, air conditioned, records included, excellent location near three hospitals and close to excellent residential area; large parking lot. Leaving in July to specialize. Contact: Michael Truman, M.D., Hamilton, Ohio — 89-54541.

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WANTED; G. P. to join clinic group in N.E. Iowa town of 75,000. Excellent opportunity; good starting salary with partnership arrangement available. Write G. W. Glenn, Business Mgr., Waterloo Surgical and Medical Group, 1125 W. Fourth St., Waterloo, Iowa 50702.

PROFESSIONAL office suite for physician or dentist available in N.E. Indianapolis (outside city limits but 30 minutes from Circle.) Air conditioned. For full details call VA3-4413 or VA3-4528.

GENERAL practice for sale, can include house and office. Or will sell practice and lease office. Contact L. H. Wiatt, M.D., 108 N. Washington St., Knightstown, Ind., or all Knightstown 5-4405 collect, after 7.00 p.m.

MEDICAL office building for lease, up to 3,000 sq. ft., 759 N. Shortridge Rd., Indpls., opposite Eastgate Shopping Center. Call now to arrange partitioning and facilities. FL7-6785.

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## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

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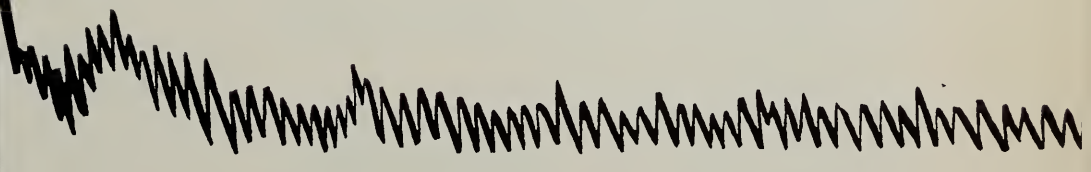
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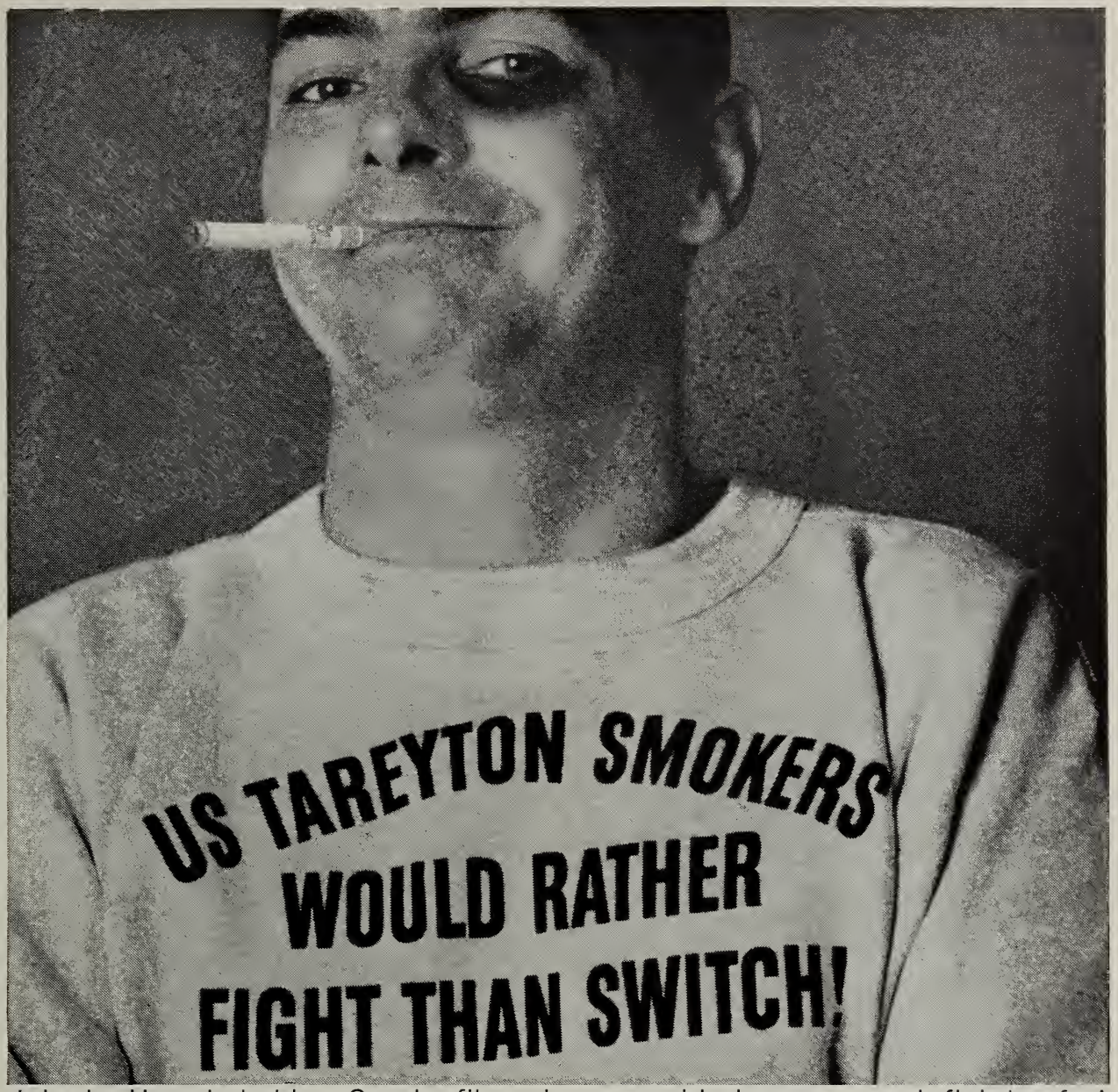
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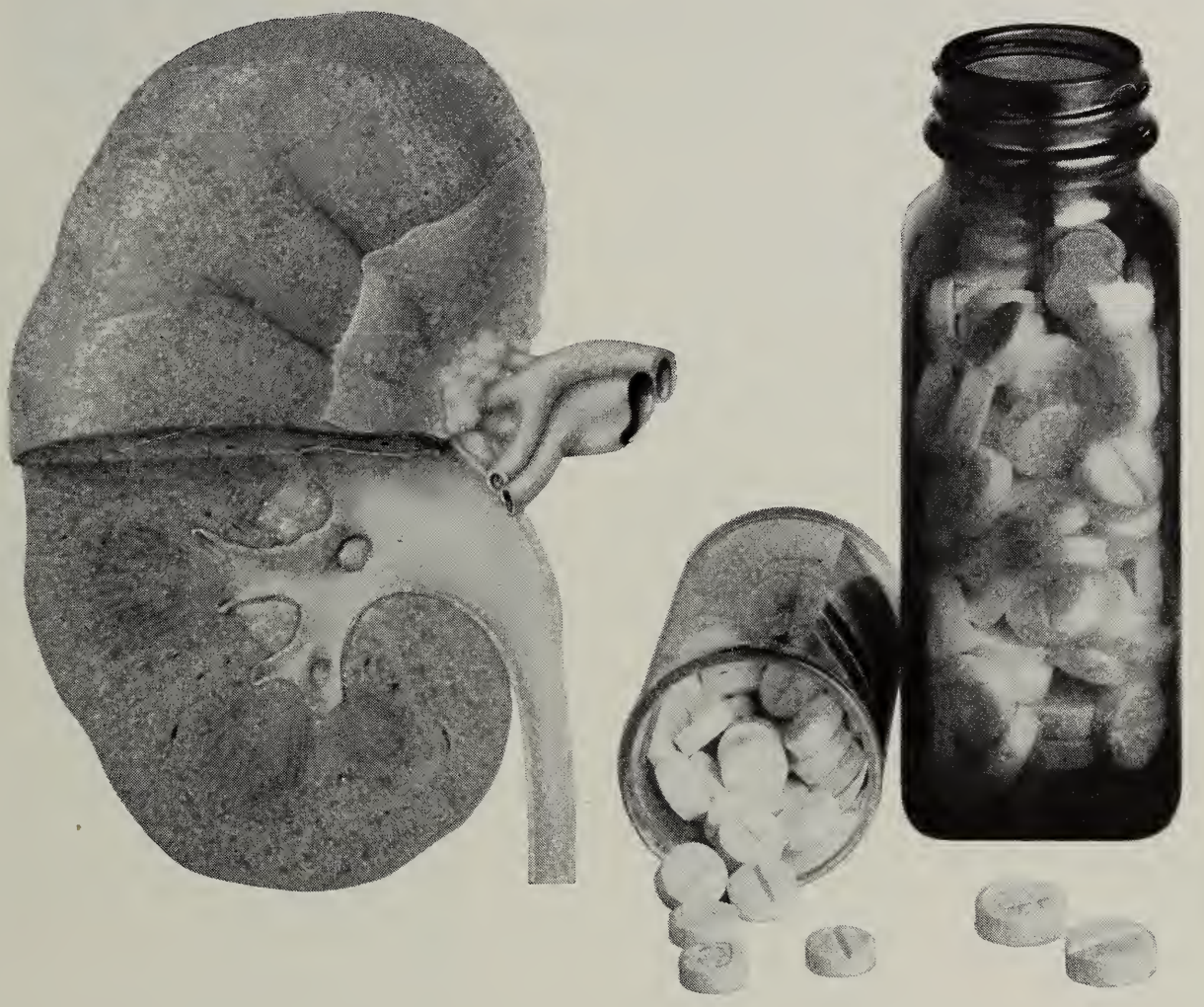
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| Wayne-Union | Paul Runge, Richmond | Joseph Zore, 1308 N. "A" St., Richmond |
| Wells | John F. Phillips, Bluffton | David G. Pietz, 303 S. Main St., Bluffton |
| White | David C. Beck, Monticello | Wayne V. Houser, 123 N. Market, Monon |
| Whitley | John L. Vogel, Columbia City | Donald B. Reid, 2 Hallmark Square, Columbia City |



# Of 341 patients with confirmed OB-GYN infections... 320 or 93.8% were treated successfully with Signemycin®

**Note:**
In 50 cases of serious puerperal and postabortal infections treated with Signemycin, complete cure was observed in 49 patients.* Duration of therapy ranged from three to eight days. Appropriate surgical measures were applied as indicated.

*Heredia Diaz, J. et al.: Medicina (Mex.) 38:308, July 10, 1958.

| Condition | No. of Patients | No. Responded to Signemycin |
|---|---|---|
| Abortion, infected | 45 | 44 |
| Adnexitis (parametritis) | 66 | 61 |
| Cervicitis | 18 | 18 |
| Endometritis | 64 | 61 |
| Mastitis and breast abscess | 44 | 42 |
| Puerperal sepsis | 14 | 14 |
| Salpingitis | 39 | 34 |
| Other ob-gyn infections | 51 | 46 |
| Totals | 341 | 320 (93.8%) |

## consistently effective...often when others fail

# Signemycin®

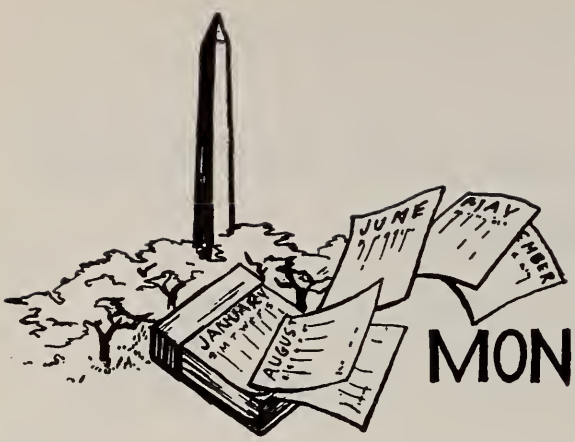
tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

*Brief Summary and Bibliography follow.*

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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

The House has passed legislation (H.R. 6675) to provide federal health care for the aged that goes much farther than the King-Anderson bill the Johnson Administration originally asked Congress to approve.

The Key House vote as far as the King-Anderson provision was concerned was on substitution of a Republican insurance plan which included some features of Eldercare which was sponsored by the American Medical Association. The vote was 236 to 191 against the GOP substitute.

The vote on final House passage of H.R. 6675 was 313 for and 115 against.

After nearly two months of hearings behind closed doors, the House Ways and Means Committee on March 23 approved the "three-layer cake" program which included a modified version of the King-Anderson bill, a supplementary government-subsidized health insurance plan for the elderly and an extensive expansion of the federal-state Kerr-Mills Program.

The committee vote was strictly on party lines — 17 Democrats for the catch-all package and eight Republicans against it.

Despite a tremendous flood of letters from the public in favor of the AMA's Eldercare plan for comprehensive health insurance for the elderly under Kerr-Mills, the House committee didn't take a vote on H.R. 3727 – the Herlong-Curtis Eldercare bill.

President Johnson quickly gave administration support to the committee bill and asked for speedy approval by Congress.

The administration-approved legislation would provide compulsory Social Security coverage, effective Jan. 1, 1966, for self-employed physicians and for interns and residents.

It also would increase, retroactive to Jan. 1, 1965, Social Security cash benefits by seven percent across-the-board with a minimum increase of $4 a month for an individual.

The wage base on which Social Security taxes are paid would be increased Jan. 1, 1966, from $4,800 to $5,600, and Jan. 1, 1971, to $6,600.

The tax rate on the new wage bases would be increased as follows:

| | SELF-EMPLOYED | | EMPLOYEE-EMPLOYER (EACH) | |
|---|---|---|---|---|
| | Present % | Proposed % | Present % | Proposed % |
| 1966 | 6.2% | 6.35% | 4.125% | 4.35% |
| 1967 | 6.2 | 6.50 | 4.125 | 4.50 |
| 1968 | 6.9 | 6.50 | 4.625 | 4.50 |
| 1969-72 | | 7.1 | | 4.90 |
| 1973-75 | | 7.55 | | 5.35 |
| 1976-79 | | 7.60 | | 5.40 |
| 1980-86 | | 7.70 | | 5.50 |
| 1987 & thereafter | | 7.80 | | 5.60 |

The Social Security tax paid by employees and employers each would be

Continued



# Of 1,028 patients with confirmed respiratory infections... 954 or 92.8% were treated successfully with Signemycin®

**Note:**
Hammerl* selected his patients for treatment with Signemycin on the basis of demonstrated bacteriological resistance to other antibiotics or failure of previous therapy. Of 100 patients with various respiratory tract infections, 95 responded to Signemycin. Pathogens isolated included staphylococci and *Diplococcus pneumoniae*.

*Hammerl, H.: Wien. Med. Wschr. 108:629, July 26, 1958.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Abscess, pulmonary | 17 | 16 |
| Bronchiectasis | 19 | 13 |
| Bronchitis | 286 | 267 |
| Bronchopneumonia | 192 | 179 |
| Empyema | 12 | 11 |
| Pneumonia, lobar | 150 | 146 |
| Pneumonia, other febrile | 160 | 150 |
| Various infected pneumopathies | 192 | 172 |
| Totals | ,028 | 954 (92.8%) |

## consistently effective...often when others fail

# Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

*Brief Summary and Bibliography follow.*

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Continued on page 410

increased next Jan. 1 from the present $174 per year to $243.60. The tax on a self-employed individual would be increased from $259.20 to $355.60.

In 1971, when the taxable wage base would be increased to $6600, the employee and employer would be paying a tax of $323.40 each, and the self-employed individual would be paying a tax of $468.60.

The legislation would provide:

KING-ANDERSON SECTION

Eligible: Persons 65 years and older

Benefits: Inpatient hospital services for up to 60 days in semiprivate accommodations (two-to four-bed) during a spell of illness, subject to a deductible, which until 1969 would amount to $40.

—Post-hospital extended care services for up to 20 days during any spell of illness in a facility which has in effect a transfer agreement with one or more hospitals or which a state agency finds has attempted to enter into such an agreement. This benefit could be extended for a period of up to an additional 80 days under circumstances described below.

—Post-hospital home health services for up to 100 visits during a one-year period following hospitalization.

—Outpatient hospital diagnostic services during a 20-day period subject to a deductible equal to one-half the deductible for inpatient hospital services.

Inpatient hospital services, post-hospital home health services, and outpatient hospital diagnostic services would begin on July 1, 1966. Post-hospital extended care services would begin on Jan. 1, 1967.

SUPPLEMENTARY INSURANCE SECTION

Eligible: Persons 65 years and older.

Cost to beneficiary: $3.00 a month, first $50 of medical bills covered and 20% of total above $50.

Benefits: Payment to the individual or to the provider of services for: (a) physicians' services, and (b) medical and other health services other than those by a provider of services as defined in the bill:

—Payments to providers of services for: (a) inpatient psychiatric hospital services for up to 60 days during a spell of illness, (b) home health services for up to 100 visits during a calendar year, and (c) medical and other health services furnished by a provider of services or by others under arrangements.

—No payment could be made under this program for any services for which the individual is entitled to have payment made under the King-Anderson section.

Administration: The secretary of Health, Education and Welfare would have to enter into contracts with carriers to administer the program.

EXPANDED KERR-MILLS

This program would combine all the vendor medical provisions for the blind, disabled and families with dependent children under a uniform program and matching formula. The federal matching share for cash payments for these needy persons would also be increased; services for maternal and child health, crippled children and the mentally retarded would be expanded; a five-year program of "special project grants" to provide comprehensive health care and services for needy children of school age or pre-school would be authorized; and present limitations on federal participation in public assistance to aged individuals in tuberculosis or mental disease hospitals would be removed under certain conditions.

Dr. Donovan F. Ward, president of the American Medical Association, said on House passage of H.R. 6675:

Continued on page 410.



# Of 425 patients with confirmed G.I. infections... 387 or 91.1% were treated successfully with Signemycin®

**Note:**
Loughlin and co-workers* achieved cure (absence of parasites) in all 100 of their patients with *chronic amebic colitis*. Feces became negative in all within the planned ten-day period of Signemycin administration. Upon re-examination of the feces six weeks later, the offending pathogen *(E. histolytica)* had reappeared in only 7 cases.

*Loughlin, E. H. et al.: Antibiot. Med. 7:739, Dec., 1960.

| Condition | No. of Patients | No. Responded to Signemycin |
|---|---|---|
| Amebiasis | 237 | 222 |
| Cholecystitis and cholangitis | 105 | 97 |
| Enteritis | 41 | 31 |
| Peritonitis | 15 | 14 |
| Various, including pancreatitis, appendicitis and colitis | 27 | 23 |
| Totals | 425 | 387 (91.1%) |

## consistently effective...often when others fail

# Signemycin®

tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

*Brief Summary and Bibliography follow.*

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## SIGNEMYCIN®

**Side Effects:** Glossitis and allergic reactions, as well as severe anaphylactoid reactions, have been reported as rare side effects. Should significant reaction or idiosyncrasy occur, discontinue medication and institute countermeasures. Use of tetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. Reduce usual oral dosage and consider serum level determinations in patients with impaired renal function to prevent possible liver toxicity due to excessive accumulation of antibiotic in the serum.

**Precautions:** Overgrowth of nonsusceptible organisms may occur. In such cases, discontinue medication and institute appropriate specific therapy as indicated by susceptibility testing. Aluminum hydroxide gel given with antibiotics has been shown to decrease their absorption and is contraindicated. The coloring agents used in Signemycin Syrup and Pediatric Drops may produce red discoloration of stools.

Triacetyloleandomycin, a constituent of Signemycin, administered to adults in daily oral doses of 1.0 Gm. (3 Gm. Signemycin) for periods of more than ten days may produce hepatic dysfunction and jaundice. In the rare patient who requires this high dosage level of Signemycin initially, liver function should be carefully followed and dosage should be reduced, as promptly as possible, to the usual recommended range of 1.0 to 2.0 Gm. per day. Therefore, Signemycin is recommended primarily for the treatment of acute or severe infections, with treatment restricted to a ten-day period. If clinical judgment dictates continuation of therapy beyond ten days, serial monitoring of the liver profile should be carried out, including BSP, transaminase, and cephalin flocculation tests. Changes observed in liver function were reversible following discontinuation of the drug.

**Formulas:** Capsules: 250 mg. Signemycin (167 mg. tetracycline HCl and 83 mg. oleandomycin as triacetyloleandomycin).

Capsules: 125 mg. Signemycin (83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin).

Syrup: 125 mg. Signemycin (tetracycline equivalent to 83 mg. tetracycline HCl and 42 mg. oleandomycin as triacetyloleandomycin) per 5 cc.

Pediatric Drops: 100 mg. Signemycin (tetracycline equivalent to 67 mg. tetracycline HCl and 33 mg. oleandomycin as triacetyloleandomycin) per cc.

*More detailed professional information available on request.*

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# Of 5,057 patients with confirmed infections of all body systems... 4,731 or 93.5% were treated successfully with Signemycin®

**Note:**
The high rate of response to Signemycin in these cases is noteworthy because the totals include many patients with difficult-to-treat infections, many whose infections had proved resistant to other agents, and many who had been treatment failures on other therapy.[1-87] In addition the following criteria were used for the cases cited: (1) only published results were used (2) results were confirmed by clinical and/or laboratory findings (3) patients were cured, not "improved" (4) dosage conformed with current recommendations in the United States (5) no other anti-infective agents were used concomitantly (6) no instance of prophylactic use was included in these tabulations.

| Condition | No. of Patients | No. Responded To Signemycin |
|---|---|---|
| Ear, nose and throat infections | 507 | 465 |
| Respiratory infections | 1,028 | 954 |
| Gastrointestinal infections | 425 | 387 |
| Genitourinary infections | 748 | 684 |
| Skin and soft-tissue infections | 1,088 | 1,036 |
| Bone and joint infections | 71 | 64 |
| Deep-seated or generalized infections | 257 | 251 |
| Obstetrical & gynecological infections | 341 | 320 |
| Miscellaneous conditions | 592 | 570 |
| Totals | 5,057 | 4,731 (93.5%) |

## consistently effective...often when others fail

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tetracycline HCl, 167 mg.; oleandomycin as triacetyloleandomycin, 83 mg. capsules (250 mg.)

Also available as Syrup, Pediatric Drops, and half-strength Capsules

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## MONTH IN WASHINGTON

Continued

"The development of this bill and its passage by the House have been characterized by unrestrained haste. It is unfortunate that the American people have been denied the opportunity to learn through public hearings just how this legislation would affect their lives. The people do not understand this bill, and it is doubtful that the members of the House of Representatives can have acted with a clear comprehension of how it would affect the nation's health, how it would affect the practice of medicine or whether physicians would be able to provide high-quality medical care under the restrictions and controls it would impose on them.

"We are opposed to increasing taxes on wage earners to pay hospital bills for everyone over 65, regardless of their income. We are opposed to centralizing control over hospitals and doctors under a federal bureaucracy. We believe in helping the elderly who need help through a program, such as Eldercare, which is administered by the states, not controlled from Washington. Public opinion surveys clearly show that a majority of the American people agree with our position.

"We hope the Senate will proceed with caution and will conduct full and fair public hearings so that this bill can be thoroughly understood by everyone. We hope that the legislation which finally emerges will be sound and just, and will reflect the desires of a majority of the people." ◄

## *About Our Cover*



Dogwood blossoming, like the appearance of the first robin, is a sure sign of spring.

Buds are popping everywhere and tulips, hyacinths, daffodils, lilac, violets and lilies of the valley are adding their beauty to the glorious warm weather.

The dark, heavy winter clothing begins to disappear and the brightly colored spring and summer outfits emerge as if triumphant. The house is poked, pushed and "powered" as spring house cleaning gets underway and the streets are dotted everywhere with trotting athletes.

These harbingers of spring also bring to mind thoughts of district meetings, the 500 Mile Race, boating, the return of cook-outs and planning that upcoming vacation.

To the doctor, however, spring brings more "tender" gifts — like broken bones and cases of hay fever, insect and/or dog bites and perhaps even a case or two of sunburn.

'Tis indeed a busy time for all.—J.F.S.

# and Robaxin®-750

## (methocarbamol 750 mg.) (CAPSULE-SHAPED TABLETS)




It has been noted that low-back disorders frequently "...are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "...muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

BRIEF SUMMARY—Robaxin (methocarbamol) Tablets: Contraindicated in hypersensitive patients. Side effects (light-headedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently.

ALSO AVAILABLE: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
Robaxisal® (methocarbamol with aspirin) and Robaxisal-PH Tablets (methocarbamol with Phenaphen®).

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# Letters

## to the editor

March 5, 1965

To the Editor:

*The Journal* of the Indiana State Medical Association constitutes a forum for medical opinion for the physicians of Indiana. As such it may see fit to print this short communication which refers to an article appearing in the March issue on "Direct Needle Puncture in the Diagnosis of Renal Mass Lesions in Infants." The technique was nicely described by Dr. Lang and its use in the case cited by the author was very appropriate. The author, however, goes on to state that "the value of this procedure is particularly shown in cases of huge Wilms' tumors that may have secondarily resulted in a nonfunctioning hydronephrotic kidney." He also says that if a suspected cystic lesion is not found "a very small amount of nitrogen mustard can be injected during the withdrawal of the needle to guarantee sterilization of any tumor cells that may be implanted in the punctured canal."

I am sure many physicians, and particularly the urologic readership of this journal will view this recommendation with alarm. In the first place, the author is not well acquainted, apparently, with Wilms' tumor which rarely causes nonfunction of the kidney making visualization by intravenous urography impossible. In the few instances in which non-function might be the result of such a tumor, retrograde pyelography is quite capable of outlining the true nature of the lesion. This procedure carries with it very little hazard of morbidity and no contamination of perirenal tissues with tumor cells. I wonder on what authority the author is able to state that nitrogen mustard will "sterilize all tumor cells that are withdrawn along the needle tract."

The case cited by the author is a very appropriate one for the use of needle puncture antegrade pyelogram. This should be limited, however, to those infants whose abdominal mass is definitely thought to be renal by intravenous urogram and transilluminates, indicating a cystic rather than solid tumor mass.

Sincerely yours,
Robert A. Garrett, M.D.
Chairman, Department of Urology
Indiana University Medical Center

The above letter was referred to Dr. Erich K. Lang, author of the article cited. His reply appears below.

March 27, 1965

To the Editor:

The comments of Dr. Garrett in reply to our article of "Direct Needle Puncture in the Diagnosis of Renal Mass Lesions in Infants" are indeed most appropriate. This particular article was primarily intended to show the use of direct needle puncture in the diagnosis of renal mass lesions felt to be of cystic nature or representing a huge hydronephrosis. Dr. Garrett took exception to the statement that injection of a small amount of nitrogen mustard during the withdrawal of the needle will sterilize the tract of any tumor cells that may have been implanted.

The author wishes to underline a statement made by Dr. Garrett that as a rule, Wilm's tumor is readily diagnosed on intravenous pyelograms and will only rarely cause non-function of the kidney. This preliminary examination alone will eliminate most cases of Wilm's tumor, and hence, the inadvertent puncture through a Wilm's tumor in the attempted aspiration of a renal mass represents a rare exception. By no means is it the intent of the author to advocate needle puncture of a mass lesion suspected to represent a solid tumor.

However, in our experience, in at least two cases, a renal or adrenal tumor had been punctured directly percutaneously by a #20 needle. In each instance, 0.05mgs. of nitrogen mustard in one cc. of saline had been injected during the withdrawal after the operator recognized that he was dealing with a solid or cystic tumor rather than a pure cyst. In neither instance did we observe any tumor implants in the puncture tract. However, even more important, in eight instances of attempted biopsy of a known

Continued on page 417.



**Side effects and precautions:** The transitory drowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few days with continued therapy, or is correctable by dosage reduction. Dryness of the mouth may be seen with higher doses. Involuntary motor activity has been reported in hospitalized patients on higher than recommended doses. Hydroxyzine HCl may potentiate CNS depressants, narcotics such as meperidine, barbiturates, and anticoagulants. In conjunctive use, dosage for these drugs should be decreased. Because drowsiness may occur, patients should be cautioned against driving a car or operating dangerous machinery. **Parenteral Solution Precautions and contraindications:** This dosage form is intended only for I.M. or I.V. administration and should not, under any circumstances, be injected subcutaneously or intra-arterially. When the usual precautions for I.M. injection have been followed, reports of soft tissue reactions have been rare. I.V. administration should be slow, no faster than 25 mg. per minute, and should not exceed 100 mg. in any single dose. Particular care should be used to insure injection only into intact veins; a few instances of digital gangrene occurring distal to the injection site have been attributed to inadvertent intraarterial injection or periarterial extravasation, both of which should be avoided. **More detailed professional information available on request.**

## LETTERS

Continued

tumor by Silverman needle technique, either 0.05mgs. of nitrogen mustard in five ccs. of saline or 20 ccs. of distilled water had been injected during the withdrawal of the Silverman needle sheet. In none of the eight cases was there any evidence of tumor implants in the area of the needle tract. It is concluded that on the basis of this observation, the method of injection of either distilled water resulting in "quelling" of the tumor cells lodged in the needle tract or small amounts of nitrogen mustard have probably significantly decreased the rate of tumor implants in the needle tract.

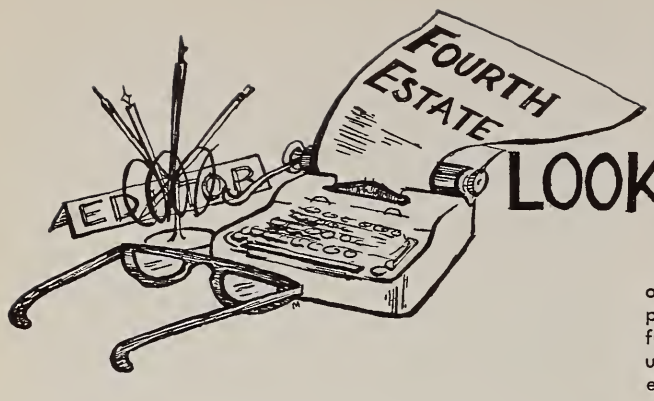
The method of destroying tumor cells by use of distilled water in the wound bed or small amounts of nitrogen mustard in water for cleansing of the wound bed has been advocated by surgeons of the Memorial Group. The hypotonicity of plain water is felt to damage tumor cells lodged in the needle sheet and decrease implants.

SUMMARY: The pertinence of Dr. Garrett's remarks as to the easy diagnosis of Wilm's tumor by intravenous pyelography is underlined. The technique of direct needle puncture in the diagnosis of renal mass lesions is primarily reserved for lesions suspected to be of a cystic nature or a large hydronephrosis of the kidney. However, the use of injection of either distilled water or small amounts of nitrogen mustard through the needle during withdrawal is advocated in cases of inadvertent puncture of tumors. In the experience of the author, supported by studies of implants in operative fields, this method significantly decreases the chances of tumor implants.

Sincerely,
Erich K. Lang, M. D.,
Radiologist
Methodist Hospital

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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Burma Surgeon

Dedication to the laying on of hands and healing marked the life of Dr. Gordon S. Seagrave, renowned Burma surgeon. He was the fourth of his family to serve as a missionary in Burma.

In 1922 he went to the Baptist Hospital in Namkhan three miles south of the China border near the Burma Road, and found a rotted wooden building, its walls filthy, and one patient. Under his direction the hovel became a 22-building hospital compound with 250 beds and 5,000 patients a year. Another 10,000 persons were treated as out-patients. The hospital contained the only medical facilities for some 400,000 persons in the area. Its fame spread around the country and some Burmese traveled 15 days on foot to get to it for treatment.

During World War II he organized mobile medical units to serve the Chinese Army over a front of several hundred miles. He was offered a commission by the British, who were in charge of the area. He turned it down lest he lose his American citizenship.

Behind the lines at base hospitals he would operate for sometimes 36 hours, dressed in khaki shorts and stripped to the waist. He and his staff of nurses were plagued by intense heat and innumerable insects. Before the advancing Japanese troops, the medical group had time only to operate, pack up and retreat, and set up again. The withdrawal led through steaming jungles and over mountains. Wracked with malaria, Dr. Seagrave arrived in India, his feet covered with sores. Decorated by the British, he was awarded the Purple Heart and made a lieutenant colonel by the United States.

He returned in 1944 to Burma with the victorious allies. Finding his hospital in ruins, he rebuilt it. Many of the cement and cobblestone buildings were designed by himself.

In 1950 he was arrested by the Burma government on suspicion of aiding tribesmen rebelling against the state. He was found guilty of high treason and sentenced to six years in prison. Accepting the verdict manfully he asked the American people not to judge the people of Burma by the actions of a few. He said, "I bear the Burmese people no malice for this." Ten months later the Burma Supreme Court cleared him of the charge. It ruled that he had erred but that there was no criminal intent when he donated instruments and medicines to a rebel tribal chieftain. Faithful to the Hippocratic oath, Dr. Seagrave had aided all the ill who came for help.

He wrote five books about his life in Burma, including "Burma Surgeon" and "Wastebasket Surgery." The latter title referred to his plea for a wastebasketful of discarded instruments while an intern. With those instruments he started his Burma practice.

It was often said that he loved the Burmese people. It was only part of the truth. It was evident that he loved all people and that Burmese happened to be the ones that populated his environment, so that his kindness mostly fell upon them.

Through the years he distributed Bible tracts, but had enough understanding of human frailties to refrain from anger when he discovered that they were often used for homemade cigarettes.

He was a dedicated man, a good man. And he was what he most yearned to be, a healer.—*Indianapolis Star,* March 30, 1965.

## You'll Get The Bill

With the help of the so-called "Medicare" bill, as passed by the House, your Social Security tax will go up about $70 next year, if you are in the maximum-coverage bracket. It will also cost your employer matching amounts for you and every other employee.

Not all of that—in fact not even half of it—is for the much-debated medical care program. Only $19.60 of next year's new individual tax and matching employer tax, at maximum coverage, is earmarked for the medical program. This will buy—if the calculations are correct—a program of hospital and nursing home benefits and certain home care for persons 65 years of age and older. The bill also offers an optional insurance program for doctor bills, with the individual paying $3 a month and the rest paid out of general Treasury funds. The cost of this feature will be buried in your general Federal taxes.

In later years the medical program costs will go up. The earmarked Social Security tax raise for this purpose will go eventually to almost $53 a year for you, assuming maximum coverage, and a corresponding amount for your employer.

The big immediate effect of the bill is an across-the-board boost in old age pensions. The bill also creates a new group of benefit recipients by liberalizing eligibility rules for certain persons now 72 or older. These changes account for the largest chunk of the tax increase.

Not all the $70 tax raise now in prospect is due to this bill. The maximum individual Social Security tax was scheduled to rise by $24 next year, in any case. That leaves about $51 attributable to the Medicare bill.

The bill includes also an increase in medical payments under welfare-administered programs. The cost of these comes out of general taxes.

Washington observers seem to take it for granted that the battle is over and the establishment of Medicare is assured. Next we begin paying for it.—*Indianapolis Star*, April 12, 1965.

## To Help Medical Progress

Announcement of expansion plans for Riley Hospital for Children is an exciting occasion for the James Whitcomb Riley Memorial Association, for the Indiana University Medical Center and for the community and the state.

That takes in a lot of territory. Riley is a lot of hospital, and is destined to be more.

The Riley Hospital operation embraces and involves the joint interests and efforts of the Riley Association, the university, other public agencies and a large number of private civic and health and welfare organizations. Through this combined support, and the skilled and dedicated work of the people of the Medical Center, Riley has been made a nationally recognized provider of the best of care for sick, injured and handicapped children.

With the passage of time, this really outstanding work has been placed under increasing handicaps of inadequacy and obsolescence of both space and equipment. The ambitious new building and remodeling program will make possible giant strides in utilization of new knowledge in arrangement, techniques and equipment. The benefits will be reflected both in the care offered to patients and in the teaching and research programs of the university.

Riley Hospital, with its several wings and its appurtenant Rotary Building and Ball Residence for Nurses, is a truly magnificent accomplishment of private effort stimulating and supplementing tax-financed operations. The original building was a gift to the children of the state from thousands of Hoosiers who contributed to a 1922 campaign conducted by the association to erect an enduring—and most appropriate—memorial to the poet, James Whitcomb Riley. A second campaign, bequests and gifts of individuals and a number of other organizations provided the other buildings and later wings. More than 190,000 individuals have made gifts to the hospital. Thousands of others have given indirectly through other organizations. Still more bequests and gifts make possible the new program.

Surely the poet, could he have foreseen what humanitarian work was to be achieved in his memory, would have been awed by it. The people of the community and the state can well take warm pride in what they have done and are doing—and

are about to do——in this institution.—*Indianapolis Star,* April 11, 1965.

## In The Wake Of Storm

Once again, in the fury of the storm, man is reminded that he and his works are puny and frail before the power of the elements.

Our hearts go out to the victims and to the bereaved. After the numbing shock there is much of suffering for some. There is much rebuilding to be done.

There also are questions to be asked. Is it not possible, with the knowledge and facilities now available, to prevent the human toll of lives and injuries in such storms?

The property damage from tornadoes, such as thundered across Indiana Sunday, is almost inescapable. It probably is possible to construct buildings to withstand the winds, but the cost would likely be prohibitive. Buildings, after all, can be replaced.

The protection of people, on the other hand, ought to be within our grasp. It is not too difficult to find or provide places of high security for people, even in the midst of a tornado's swath of destruction. At almost everyone's hand today is means of transportation swift enough to outrun any tornado—if you know which way to run. In radar the means is available to locate tornadoes and calculate their paths. Instant communication is at our fingertips.

It is by no means certain that people, adequately warned, would seek safety. Human nature is often perverse on that point. But all practical opportunity should be provided.

With the technical equipment and knowledge ready to our hands, it should be quite feasible to track tornadoes and other killer storms and keep people informed as to where they are and where they are heading —not just in terms of general area warnings covering periods of hours but in pinned-down specifics. This is something to work on.—*Indianapolis Star,* April 13, 1965.

## The Rescue Workers

Thousands of Hoosiers hurried selflessly to help their stricken neighbors and friends within minutes after Sunday night's catastrophic tornadoes, brightening what was in all other ways a dark and grim hour in our state's history.

The Indiana State Police, city police, firemen, sheriffs and their deputies were among the first to answer the call to help victims of the disaster. City and town officials, National Guardsmen, civil defense police, the Salvation Army, the Red Cross, doctors, nurses, ambulance drivers, telephone and electric crews and supervisors worked throughout the night and on into the next day in the massive emergency tasks.

They were joined by uncounted thousands of volunteers who often at their own peril searched through storm-shattered buildings for the injured and transported them to first aid centers or hospitals.

The looting of storm-wrecked homes and businesses by a handful of ghoulish marauders was a bitter contrast to the labors of these generous men and women.

The volunteers have set an excellent pattern for the immense task of recovery that lies ahead. Indiana can be proud of them. —*Indianapolis Star,* April 13, 1965. ◄


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# Benign Jaundice: The Dubin-Johnson and Rotor Syndromes

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*Indianapolis*

SYNDROMES of benign jaundice with elevation of both direct and indirect serum bilirubin were described by Rotor in 1948,[1] and Dubin and Johnson in 1954.[2] Although both syndromes are benign, they are clinically important because they may be mistaken for either chronic hepatitis or surgical jaundice. Thus, recognition of either syndrome will prevent chronic invalidism or surgery, and allow a normal life despite the presence of jaundice. The purpose of this paper is to present the main features of both syndromes, and report a representative case history of each.

The syndrome of chronic idiopathic jaundice described by Dubin and Johnson was also reported independently by Sprinz and Nelson in 1954.[3] This syndrome is most commonly recognized in young people in the first to third decades. They may have a family history of jaundice. The onset of jaundice may be insidious, but in many it is associated with symptoms of nausea, anorexia, weakness and abdominal pain. About half the cases have a slightly enlarged liver which may be tender. The clinical icterus may be chronic or intermittent.

Usually the only abnormal laboratory tests are those concerned primarily with excretory function. Thus bromsulphalein (BSP) retention is usually over 10%, and there is little or no visualization of the gallbladder with oral contrast media. The total bilirubin fluctuates, and may be as high as 20 mgm/100 ml; both the direct and indirect fractions are elevated, with at least 50% of the total present as the direct form. There is usually increased excretion of urobilinogen in the urine and bilirubinuria. Gross inspection of the liver at laparotomy or by needle biopsy reveals a peculiar discoloration which may be dark green, slate blue or black. Diagnosis is made by histologic examination which reveals the presence of a lipochrome-like pigment in the liver cells.

Although considered a benign disorder, the icterus and symptoms of the Dubin-Johnson syndrome apparently may be precipitated or aggravated by a number of factors; these include excessive alcohol ingestion, pronounced physical activity, intercurrent infection, and perhaps a surgical operation. Pregnancy may also be associated with exacerbation but gestation and delivery are unaffected. Prognosis is excellent, for long-standing cases have been observed without evidence of progressive hepatic dysfunction or damage.

The Rotor syndrome consists of chronic, fluctuating, relatively mild jaundice noted in the first or second decade of life. It also appears to be familial, but is asymptomatic. The total serum bilirubin ranges from four to 23 mgm/100 ml, with the varying values of direct and indirect fractions about equally divided. BSP retention is marked, ranging from 50 to 65% at 45 minutes. Oral cholecystography, urine urobilinogen and stool stercobilinogen are all normal, but bilirubinuria may be present. All other liver function tests are usually entirely normal, and liver histology is normal. The Rotor syndrome is also apparently compatible with a normal life, but the jaundice may be deepened by the same factors that aggravate the Dubin-Johnson syndrome.

### Case Reports

*Case 1.* A 23-year-old, married, white, female schoolteacher was first noted to be

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jaundiced in 1959, at age 18. At that time she did not feel ill, but was hospitalized because of the possibility of infectious hepatitis. Physical examination revealed only scleral icterus. The urine was positive for bile, but there were normal values for urine and fecal urobilinogen. The total bilirubin was 3.1 mgm%, with 1.2 mgm% direct and 1.9 mgm% indirect. A repeat total bilirubin was 2.8 mgm%, with 1.2 mgm% direct and 1.6 mgm% indirect. Thymol turbidity, cephalin flocculation, alkaline phosphatase and routine laboratory examinations were normal. Oral Telepaque produced good visualization of a normal gallbladder. She was discharged with the diagnosis of infectious hepatitis.

She remained entirely well for four years. In late October, 1963, she was involved in an automobile accident and subsequently consulted a physician. He noted the presence of jaundice, but told her it was non-specific and had no significance. She then developed fatigue and vague upper abdominal pain, and around the middle of December, 1963, she consulted another physician who made a diagnosis of hepatitis. She was given an injection of gamma globulin, and placed at bed rest at home for three weeks. During this time her strength improved, but her jaundice remained, and she was referred for further evaluation, entering Methodist Hospital in Indianapolis on January 8, 1964.

At the time of admission, the patient was completely asymptomatic, specifically denying nausea, anorexia and any change from normal of her stool and urine. She had not received parenteral injections for over six months. She stated the plumbing and sewage facilities where she lived were in proper working condition. The fatigue which she had experienced about one month prior to admission had completely disappeared and she felt strong and well. However, she was quite apprehensive about her continued jaundice. The only "medicine" she had taken recently was an oral contraceptive from October to December, 1963; her fatigue, a reported side-effect of these agents, ceased after discontinuance of the drug. All further system reviews, past and personal history were non-contributory. There was no known family incidence of jaundice.

Physical examination revealed moderate scleral icterus, and mild right and left upper quadrant tenderness, although no organs or masses were palpable. The remaining examination was entirely normal.

The admission blood count was normal, and VDRL was non-reactive. The urine was clear, but the two hour urine urobilinogen values were 4.2 and 2.2 units on two occasions, and 0.51 on another (normal: 0.3 to 1.0 unit). Three total bilirubins ranged from 2.3 to 3.9 mgm%, with the direct fraction 50% or more of each total value. BSP retention was 3% at 45 minutes (normal 0 to 5%). Alkaline phosphatase, cephalin-cholesterol, thymol turbidity, total proteins, SGOT, cholesterol and cholesterol esters, coagulation time, prothrombin time, bleeding time, clot retraction, osmotic fragility, Cutler sedimentation index and chest x-ray were normal. Oral administration of 12 tablets of Telepaque produced poor visualization of the gallbladder, and a repeat study likewise revealed poor definition and concentration but there was no demonstration of any other abnormality.

A needle biopsy of the liver was performed and the gross specimen was a peculiar dark chocolate color. Microscopic examination revealed normal architecture, but the presence in the central lobular area of a granular, non-refractile pigment which was not iron-stain positive (Figure 1). The final diagnosis was chronic idiopathic jaundice with Dubin-Johnson hepatic cell pigmentation. After an uneventful hospital stay and prompt recovery from the needle biopsy, the patient was discharged with instructions to live a normal life, avoiding an excess of alcohol, severe physical activity and fatigue. She was entirely well three months after discharge.

*Case 2.* A 12-year-old white female was admitted to Methodist Hospital on March 11, 1962, for investigation of jaundice of nine months duration. She was first found to be jaundiced in July, 1961, when tests revealed a normal blood count but a total bilirubin of 3.36 mgm%. A tentative diagnosis of hepatitis was made and the patient was placed at bed rest for two weeks.

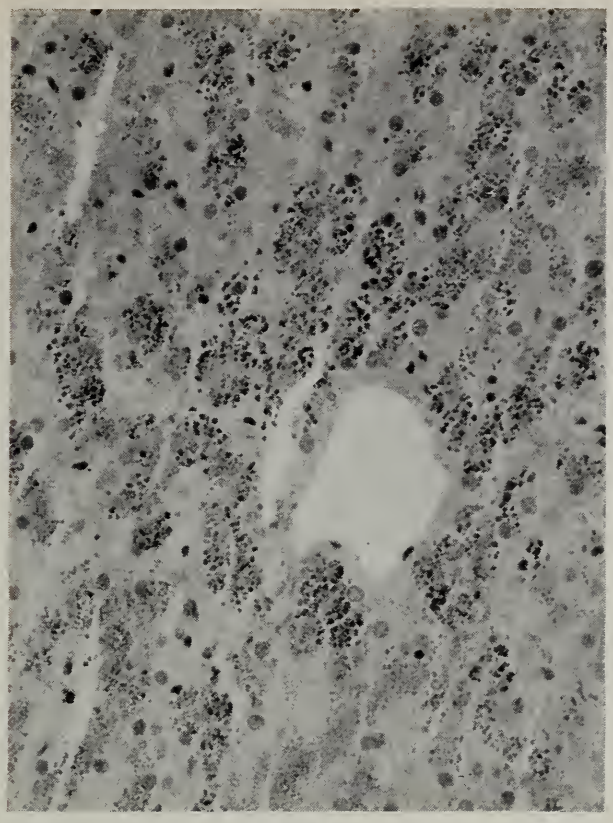


FIGURE 1

CASE 1, Dubin-Johnson syndrome. Prominent pigment granules are more concentrated in the centrolobular area; the hepatic cells are otherwise normal. Hemotoxylin and eosin stain, x250.

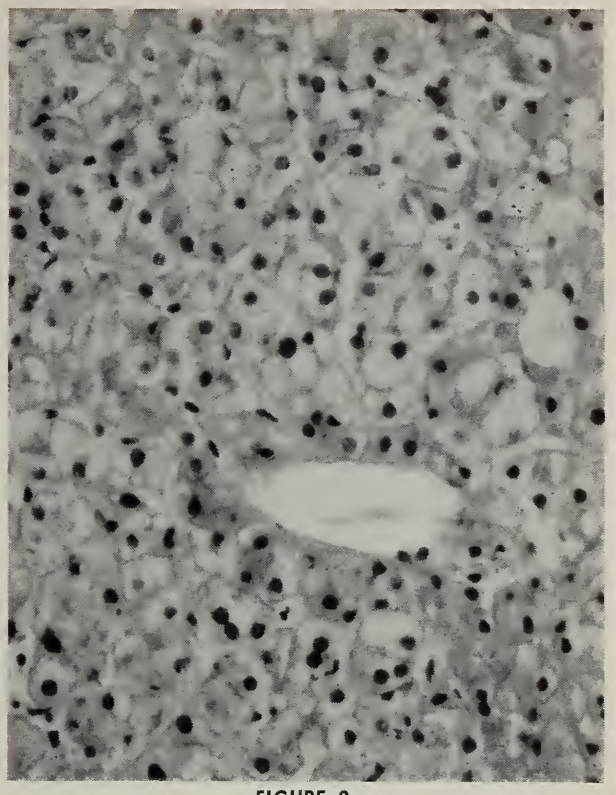


FIGURE 2

CASE 2, Rotor syndrome. The liver, as seen in the needle biopsy, is normal. The clear cytoplasm of the hepatic cells is probably associated with a high glycogen content. Hemotoxylin and eosin stain, x250. Photomicrographs and descriptions by Dr. Edwin E. Pontius, pathologist, Methodist Hospital Graduate Medical Center.

During this time the patient had none of the usual symptoms of hepatitis. Her appetite remained good and her liver was never enlarged. The serum bilirubin was then repeated, and revealed a total of 4.6 mgm%, with 1.6 mgm% direct, and 3.0 mgm% indirect. The patient was admitted to a hospital for six days, and was found to have a normal cephalin flocculation and alkaline phosphatase; she was discharged with the diagnosis of recurrent viral hepatitis.

Her total bilirubin remained elevated between 3.2 and 3.8 mgm% until November, 1961, when a BSP study revealed 65% retention at 30 minutes. She was referred to another physician, and again hospitalized in December, 1961. Laboratory tests, including those of liver function, were again entirely within normal limits except for total bilirubins ranging between 3 and 4 mgm% and a BSP of 42.6% retention at 45 minutes. The patient was discharged, but placed at bed rest for two months. At the end of that time the total bilirubin was 3.65 mgm%, and the BSP retention 30.7%. She was then referred for more definitive study and admitted to Methodist Hospital.

The patient felt perfectly well, and had experienced no difficulty attending school part time when not in the hospital or at bed rest. The mother stated that the patient had always "looked sort of yellow" to her. A history of light-colored stools or dark-colored urine was specifically denied. The patient's birth and developmental histories were entirely normal; her past history and symptom review were non-contributory.

Family history revealed that one brother had been jaundiced during a febrile illness when he was five years of age.

Physical examination on admission revealed mild to moderate jaundice, but otherwise was entirely negative; the liver was neither tender nor palpable. The blood count was normal, and the VDRL was non-reactive. The urine was grossly and microscopically clear, and the two hour urine urobilinogen was normal. The total bilirubin was 4.4 mgm%, with both direct and indirect 2.2 mgm%. The BSP (5 mgm/Kg) retention was 33% at 45 minutes. The

SGOT, SGPT, thymol turbidity, cephalin-cholesterol, alkaline phosphatase, serum proteins, coagulation time and bleeding time all were within normal limits. The prothrombin time varied between 59 and 75% (15.9 and 15 seconds).

A needle biopsy of the liver was performed and microscopic examination was entirely normal (Figure 2); there were no bile plugs and no abnormal granules were demonstrated by both iron and PAS stains. The patient had an uneventful hospital course except for a mild reaction following intravenous vitamin $K_1$. She recovered well from her needle biopsy, and was discharged 13 days after admission.

Laboratory work on the parents while the patient was in the hospital revealed the father's serum bilirubin to be normal. The mother's serum bilirubin was questionably elevated, with 0.0 mgm% direct and 1.45 mgm% indirect.

## Discussion

These two cases illustrate well the typical clinical and laboratory findings of their respective syndromes. The patient with Dubin-Johnson syndrome (Case 1), whose jaundice was discovered late in her second decade, had bile in her urine on one occasion and increased urine urobilinogen on two of three occasions. All of her liver function tests were normal, but her serum bilirubin was always between 2 and 4 mgm%, with the direct and indirect fractions usually about equal. She had mild upper abdominal pain which was almost certainly not connected with the automobile accident. Her oral Telepaque gallbladder x-ray series showed faint visualization while in our hospital, but five years earlier at another hospital, the oral administration of contrast medium produced good visualization, an atypical finding in this syndrome. The other atypical feature was the normal excretion of bromsulphalein. The needle biopsy, however, produced a diagnostic specimen.

The patient who had a Rotor syndrome (Case 2), whose jaundice was discovered early in her second decade, had a familial history of jaundice. Her total serum bilirubin levels varied between 3 and 5 mgm%, and the direct and indirect fractions were approximately equal. Her liver function tests were entirely normal, except the BSP, which was reported as high as 65% retention at 30 minutes. Needle biopsy of the liver, performed during a time she was clinically jaundiced, was entirely normal.

These two cases exemplify the forced invalidism and time lost from productive activity because the benign nature of their jaundice was not realized. The pitfall of incorrectly diagnosing biliary tract pathology in these syndromes has been reported by Berkowitz.[4] His report concerns a 29-year-old Negro male who had abdominal pain, right upper quadrant tenderness and jaundice. His gallbladder failed to visualize and laparotomy for presumed cholelithiasis revealed a normal biliary tract. However, gross liver discoloration was noted and on subsequent microscopic examination, the histologic picture of Dubin-Johnson pigmentation was seen.

There are excellent reviews and case presentations of these two syndromes in the literature,[5-14] including a follow-up of 50 of Dubin's cases,[15] reviews of bilirubin metabolism[16-22] and discussions of the relation of these two entities to the general category of congenital defects of bilirubin metabolism.[23-26]

The actual defect in the Dubin-Johnson and Rotor syndromes is unknown. However, the abnormal laboratory findings of BSP retention and failure to obtain gallbladder visualization with contrast medium point to an abnormality in the excretory phase of bilirubin metabolism. The hyperbilirubinemia which includes an increase of the indirect fraction specifically implicates a defect in the transport of conjugated bilirubin from the parenchymal cells. Dubin considers the presence of pigment in the Dubin-Johnson syndrome indicates a defect in excretion of lipofuscin, which the pigment resembles.[15] The exact nature of the pigment, and its relationship to the functional defect is unknown, however, and the same type of pigment has even been described in the absence of jaundice.[27] Popper and Schaffner have examined liver specimens from cases of Dubin-Johnson and Rotor syndromes by electron microscopy and found the bile canaliculi to be normal. These findings are distinctly different from the abnormalities observed in intrahepatic

cholestasis and extrahepatic obstruction, which are also causes of hyperbilirubinemia with conjugated bilirubin in the serum.[28] Schoenfield[21] and others consider the possibility of the Dubin-Johnson and Rotor syndromes being variants. Indeed, Arias has relayed to Schiff information concerning a family under study with both syndromes present within the one family; the members include two siblings, one of whom has the Dubin-Johnson syndrome and the other the Rotor syndrome.[25]

Arias has commented on the effects of drugs on these syndromes.[23] He reports that neither ACTH nor adrenoglycocorticoids have affected the jaundice. He states, however, that because some drugs in high dosage, namely norethandrolone and methyl testosterone "appear to alter the hepatic excretion of bromsulphalein and conjugated bilirubin, it seems appropriate that these drugs should not be administered to patients who presumably already have defects in hepatic glucuronide formation" (or excretion).

## Summary

The Dubin-Johnson and Rotor syndromes are benign causes of jaundice which are clinically important because they may be mistaken for hepatitis or surgical jaundice. Hyperbilirubinemia with elevation of direct and indirect fractions is present in both syndromes. In addition, the Dubin-Johnson syndrome may be symptomatic; the gallbladder visualizes faintly, if at all, and a lipochrome-like pigment is present in the liver cell. The Rotor syndrome includes marked BSP retention. As stated by Schiff, "recognition of these entities avoids treatment for the wrong diagnosis of hepatitis or biliary tract disease and provides a basis for reassurance and favorable prognosis; they are benign conditions not requiring therapy."[25]

A case report of each syndrome is presented and theoretical considerations concerning etiology are briefly discussed.

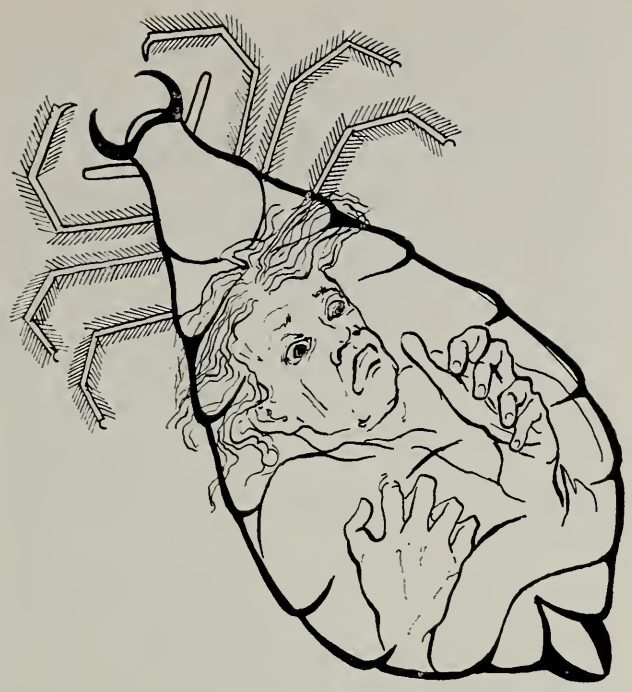
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## DO YOU HAVE A HEMOPHILIAC PATIENT?

**The Indiana State Chapter of the National Hemophilia Foundation is seeking information as to the number of hemophiliacs in Indiana. Medical practitioners throughout the state treating hemophiliac patients are urged to send the names, ages, addresses and details of the type of hemophilia of such patients to Mr. S. T. Friedman, Secretary of the Medical Advisory Council of the Indiana State Chapter of the National Hemophilia Foundation, 3946 Washington Blvd., Indianapolis 5.**



# The Case of the Furious Flitting Phantoms

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

COMPUTERS can supply answers to problems that baffle the human mind; modern medicine has gadgets to give affirmative replies to our previous educated guesses. But the robot is not *human*,—a machine cannot be *humane*. Sympathy, compassion and consideration for all living creatures, human or animal are the hallmarks of the true healer. Avoiding further sententiousness, let us proceed.

The wintry day was bleak and dreary; it was late afternoon; the Christmas holidays were over. The New Year had brought its crop of inexperienced house staff; the wise attending physician could save many headaches by making himself conspicuously available.

The young intern from the Orient was almost pathetically grateful at the appearance of an older colleague. He had been in our country only five days; his book English was excellent but the spoken words came haltingly and with inflections not always comprehensible to American ears.

The hospital ward was buzzing with activity. A case of acute pulmonary edema had been thoroughly examined; the written orders had been spelled out meticulously. I praised the doctor for work well done even as I went on to the next patient. Terminal carcinoma produces stupor: there was no pain. The energetic new physician had written a thorough history, performed a meticulous physical examination and had compiled a couple of pages of various orders. Quietly, I embarked on a philosophical discussion deploring the tendency to insist on the last extractable breath. Was euthanasia justifiable? We doctors were *not* God; when was masterful inactivity a necessity? Just what did we mean by "Dignity in Death?" Anyhow—every orifice of the body was *not* catheterized; massive blood transfusions were *not* initiated; stimulation was not maximal and sedation was adequate. A screen gave precious privacy shielding the patient from the humming ward and afforded the hovering relative almost the luxury of a single bed room.

Other cases were less dramatic. A severe diarrhea had been diagnosed correctly as a toxic thyroid. After complimenting the young man on so astute an appraisal, we discussed briefly the various desirable laboratory tests; clinical observation was emphasized—its importance in diagnosis was stressed. Several other charts were gone over; they were all on the mundane side. As I was preparing to depart, I glanced into the "consults" box. In it was a lone sheet addressed to the psychiatrists; a "severe schizophrenic depression" needing their evaluation.

"Who is she?"

"Oh, this case is very pathetic: Only 55 years old, too! Imagines she is crawling

with lice; has to be restrained from scratching herself to pieces. A lot of private doctors have tried all kinds of treatments. The children are most solicitous but they can no longer keep her in private hospitals. Ah, yes; very distressing!"

**Present and Past Pediculophobiac Patients**

The woman had been brought in that very morning. The nursing supervisor, the intern and I trooped to the semi-private porch holding only three beds. There was no difficulty in identifying the patient. Swathed like a mummy in concealing layers of bandages and held in firm restraints, she was tugging in a constant effort to free herself. In a continuing monotone, she was almost chanting, "VSHY MEENIA SEE-DAH-IUT"—Polish words meaning, "The lice are eating me up."

The anxious children fluttering around the bed—the shackled, swaddled mother—that endlessly repetitious phrase: Where? When? Aposiopetically, the gear-box of memory was jammed! Even as I picked up the chart, I tried hard to delve deeply into the tantalizingly hidden past that I just *knew* to be so pertinent to the clamoring present. And — suddenly — the gears meshed! The place, the time and the events were recalled precisely! That Polish phrase was the lever clicking the memory gears that drove me back in time.

Once again I became the resident at Cook County Hospital in Chicago, my attending physician was the already legendary Dr. Frederick Tice, the greatest clinician of his day — the original author of the still extant loose-leaf *System of Medicine* that still bears his name. We went to the locked section of the psychopathic ward. He had been called to see a woman who had developed a maniacal compulsion to scratch herself. Restraint became mandatory; she could not be permitted to tear herself to pieces. All treatments by private physicians had been unavailing; commitment seemed to be the only channel possible. Her son was a very influential politician; that is how Dr. Tice had come to be consulted.

The psycho ward resident had been alerted to our arrival; he was our escort to the proper cubicle. In those days, paraldehyde was the standard sedative for manics. It was prescribed in two ounce doses; yes, 60 cc.! Its rancid reek was the effluvium pervading the demesne of the demented. Parenthetically, one might add that some persons have been known to become addicted to its use. I was even told of a certain inmate who took paraldehyde via urinary catheter! In such fashion, she took care of other basic urges also.

The patient we had come to examine was shrouded in concealing bandages and held in firm restraints. She was moaning over and over the identical phrase I was not to hear again for 35 years, "VSHY MEENIA SEE-DAH-IUT", the lice are eating me up.

Tice listened with grave attention as I translated the Polish phrase to him. "Notice, dottor! (He never said, doctor). There is a white reflection from both her pupils. Her cataracts are about ripe and she must be almost blind. Tell her who we are; ask her whether she can see us."

Dr. Tice was famous for his ability to observe the seeming trifles, make nigh miraculous inferences and go on to unerringly correct diagnoses. Dr. Bell may have been Dr. Conan Doyle's prototype for Sherlock Holmes, but Dr. Tice would have served equally well — my chief could perceive, correlate and deduce; he taught his staff these virtues by precept and patient exposition. . . .

The question was asked; indeed, she could but barely make out the fingers held before her. I was just a blur in front of her. She "thought" I wore a white jacket.

"And what was that skin trouble for which you went to the doctor in the first place?" She did not know. It was the turn of her hovering son to wax voluble, "Itch mites — scabies the doctor called it."

Once launched, the son went on, "The skin specialist dug a couple of them from out of the blisters and showed them to us under the magnifying lens. He said it was much like the cooties we had while in the trenches during the war. The ointments he used killed the creatures but we could not convince mother of that. She kept on scratching and carrying on until we just *had* to bring her to this place. What else could we do?"

The son appeared very intelligent; his

history was punctuated by the mother's droning monotone, "VSHY MEENIA SEE-DAH-IUT," the lice are eating me up. My imperturable chief had been weighing the entire situation even as he had listened, looked — and decided. He moved to the patient's side and took her hand. "Please, tell her who I am! Can she see me?"

It took a while but contact was established. "Now, nurses! Remove the bandages and restraints; let us see what goes on!"

This took more time but Tice was not to be hurried. The frightful excoriations with their secondary pustular infections were laid bare for all to see. A few sarcoptei could still have been hiding there but the extreme neurodermatitis was the all too obvious source of our difficulties.



### Cacopsiac Cnesomania

Speaking to no one in particular, Dr. Tice first suggested to us that we read up on scabies either in Merck's *Manual* or, else, in Ormsby's *Diseases of the Skin.* Then, he went on with a professorial summation: "This lady *DID* have some scabies. We know the terrible intensity of the itching; we know the difficulties of attaining a complete cure while avoiding OVERtreatment with its attending irritant, contact dermatitis. Now the patient is all but blind. She had been told the cause of the itch; she could not discern anything *on* her skin. She itched and she scratched; the skin cover became infected: a vicious cycle was established. She could not see but she could *feel* and she *imagined* even more: The *fury* of the *flitting phantoms* has been a total reality to this poor woman. It is our duty to treat the whole patient! She must have absolute assurance that we can and will remove the canterkerous cooties that have converged on her cutis.

"Now, please, tell her the following — exactly as I say it. First, there is no question about the serious condition that you have. The doctors attending have been excellent but they have not quite grasped your problem. Fortunately for you, we have the right medicines and know exactly what to do. However, it is exceedingly important for you to follow instructions explicitly as ordered. Only that way will *ALL* the causes of the itching be destroyed; then — and only then — will you be cured.

"The nurses will be supervised by the doctors; the right medicines will be applied and given to you today and every day. You will receive the precise ointments and pills as you need them. It should not take too many weeks. You will WALK out of this hospital."

Dr. Tice was slow and emphatic; he made certain that, as I translated, Mrs. Zawadski comprehended fully. He took the time to see the anesthetic lotions applied. He repeated the raison d'etre for agreeing with the patient that some itch mites were still there but that the treatments would remove them completely.

He asked me to get in touch with the renowned hypnotist, Dr. Gonda, a famous psychiatrist on the Cook County Hospital attending staff.* The powers inherent in this modality (when in the right hands) are not to be minimized. As usual, Dr. Tice's clinical instincts were unerring. Events took their guided course; the lady did walk out of the hospital: I made a reference to this very amazing case in an article on Cook County Hospital that I wrote for the *University of Chicago Alumni Magazine* back in 1933.

### Suaviter in Modo

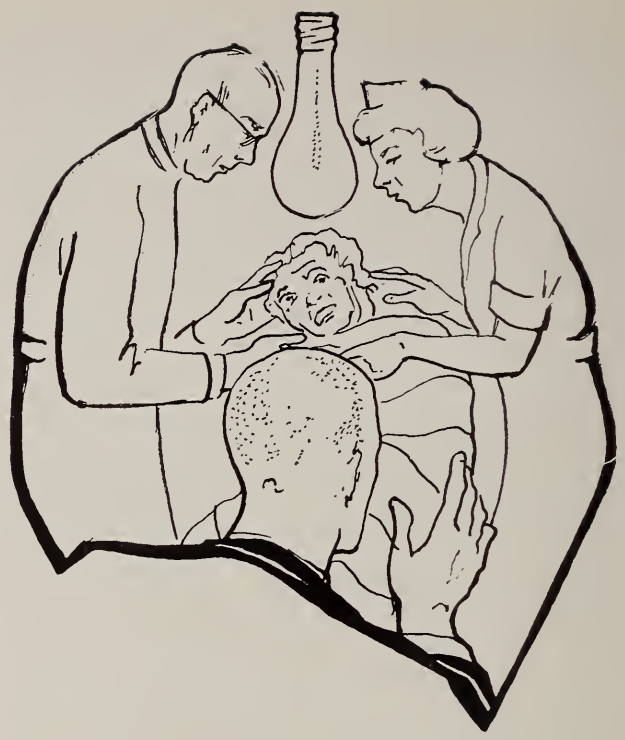
Computers are marvelous machines, indeed, but human memory retrieval is not bad. Even as I stood at the foot of the bed,

* Gonda reflex.

the New York woman's chart in my hand, my mind had traveled back to the Cook County Hospital in the Chicago of 35 years ago. The reel of recollection ran through total recall in a mere handful of seconds. I basked in the luminous reflection of Dr. Tice's personality even as I savored again his wisdom, humanity and compassion. "The lice are eating me up!" Chicago then, New York now, a very full generation later! The blind Polish mother — Mrs. Zawadski or Mrs. Zaleski! Dr. Tice had long left this world; it was my bounden duty to be his deputy. A very large order, indeed: but, the script had been spelled out for me in meticulous detail — no rehearsals were needed.

Still holding the chart in my hand, I looked earnestly at the woman's face. Yes, the pupils gave the unmistakable light reflex of the ripening cataracts. Speaking slowly, in Polish, I asked the patient whether she could see me? But barely! Could she see the 50 watt bulb in the stand by the bed? Very dimly! I asked the aide to bring the brightest bulb available. Also, I requested the removal of the restraints and bandages. While waiting, I talked to the patient as she emerged from her cocoon of bandages. I used the very questions my late chief had asked. Not surprisingly, the answers were the same. The time and the place was different; the cases were the same!

The 250 watt bulb helped me greatly with the rather crude but, oh, so effective effort of hypnotic suggestion. This is not a procedure to be recommended for routine use; however, Dr. Gonda had been an efficient instructor and my patient proved most susceptible, indeed. We used more modern ointments and oral medicaments than those prescribed by Tice — after all, time marches on; we now possess tran-



quilizers and antibiotics.

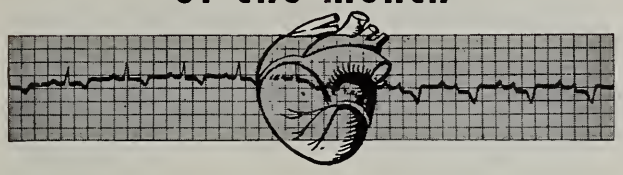
However, I did not deviate from my beloved chief's meticulously outlined program of getting into total rapport with the woman and her family. And, results were forthcoming now just as they had been 35 years before.

Also, my Far Eastern colleague paid me a most heart-warming compliment. "I thought that all Americans were supposed to be so cold blooded but you certainly displayed a maximum of personalized sympathy."

I checked the impulse to sermonize. I did mention Dr. Albert Schweitzer and his creed of "compassion for life." Dr. Tice had imprinted the lesson on me. I do hope that — now and then — I can help pass the torch to still younger generations who, in their never ending turn, will pass it on and on! ◄

1270 Fifth Ave.
New York, N.Y.

# Electrocardiogram
## of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Reciprocal Rhythm*

*CHARLES FISCH, M.D.*
*Indianapolis*

A-V NODAL IMPULSE with retrograde conduction into the atria may, due to depression of A-V conduction, be delayed sufficiently long so as to be able to "return" and excite the ventricle. As a result, reciprocal beating can be recognized by a QRS which is usually A-V nodal in origin followed by an inverted P which appears to be "sandwiched" between the nodal QRS and a subsequent closely spared QRS complex.

Tracing recorded on 6-27-63 shows an A-V nodal rhythm with a ventricular rate of about 35 per minute followed by retrograde conduction to the atria after a R-P of 0.28 seconds (Top of Figure 1). On 7-2-63, the basic A-V nodal rhythm persists but the R-P is now 0.32 seconds (Bottom of Figure 1). This prolongation of retrograde conduction was sufficient to allow for a "return" activation of the ventricle resulting in two QRS complexes with a P wave "sandwiched" in between.

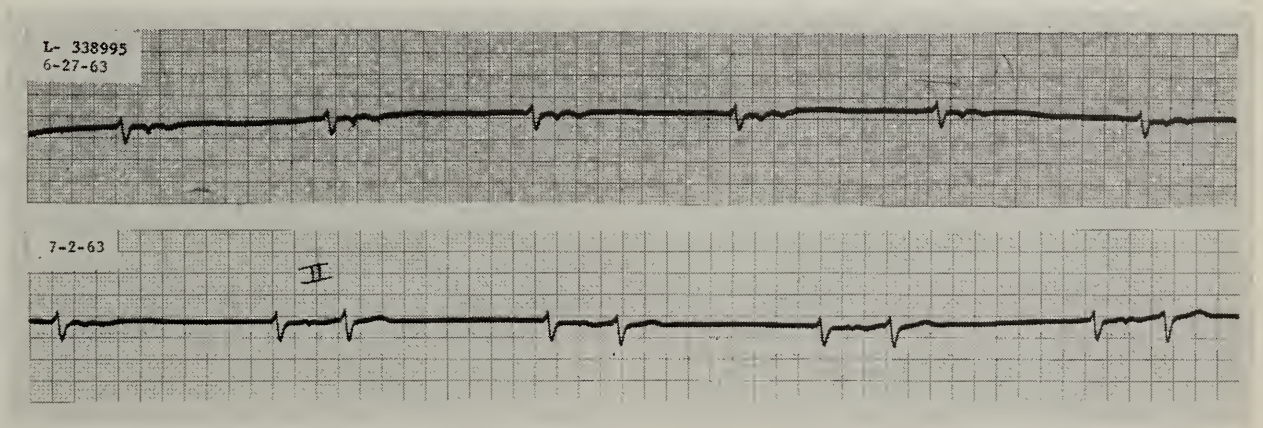



**FIGURE 1**
**THIS figure shows reciprocal rhythms. For details see text.**

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Volvulus of the Cecum

ERICH K. LANG, M.D.*
*Indianapolis*

A 78-year-old inmate of Central State Hospital was transferred to Methodist Hospital because of acute abdominal distress. At the time of admission, the abdomen was hugely distended and tympanitic. There was no rebound tenderness, however the patient complained of diffuse pain throughout the abdomen. A flat plate and lateral film of the abdomen revealed a huge distended bowel loop, extending from the left lower abdominal quadrant all the way across to the right lower and right midabdominal field (Figure 1).

The lateral film showed this greatly dilated bowel loop to occupy the entire anterior lower abdominal cavity. Distended small bowel loops were seen in the midabdominal field, and appeared to have been displaced by this distended loop from the true pelvis and the lower abdomen (Figure 2). The appearance of this sausage-shaped bowel loop, measuring more than 18cms. in diameter and its characteristic position established the radiographic diagnosis of volvulus of the cecum.

The volvulus was reduced surgically. The patient had an uneventful recovery and was returned to Central State Hospital.

### Comment

Volvulus of the sigmoid colon or cecum is often considered a disease of infants. However, volvulus, particularly of the cecum, is encountered quite frequently as an abdominal emergency in inmates of mental institutions. The roentgenographic appearance of volvulus of the cecum and sigmoid on the plain film of the abdomen is quite characteristic and the diagnosis is readily made. The diagnosis of volvulus of the large bowel should be kept in mind in examining inmates of a mental hospital in acute abdominal distress. ◄

* Department of Radiology, Methodist Hospital, Indianapolis.



FIGURE 1

NOTE the hugely dilated bowel loop filling the entire lower abdominal field from the left lower abdominal quadrant to the right midabdominal field. The loop is distended to 18cms. in cross diameter. Dilated small bowel loops are displaced from the lower abdominal field into the mid and upper abdominal field.

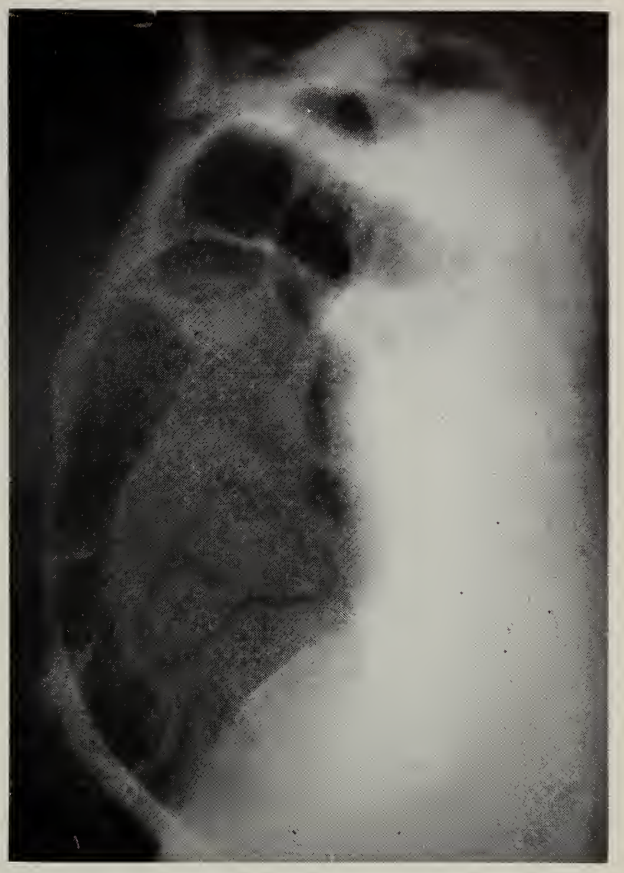


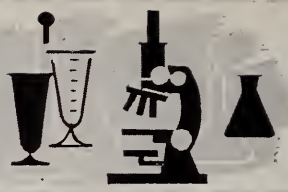
FIGURE 2

A HUGE dilated cecum occupies the entire lower and midabdominal field anteriorly. The small bowel loops are displaced into the upper abdomen. The abdominal wall bulges due to this distended cecum.

## NEXT MONTH IN *THE JOURNAL*

**Dr. Irvin Caplin, Indianapolis, will discuss the potential and real dangers inherent in the use of foreign serums in his article on "Skin Testing for Tetanus Antitoxin."**

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



# The Myth of "Objective" Laboratory Report

LEON L. BLUM, M.D.
Terre Haute

STRIKING TECHNOLOGIC and scientific advances in all branches of medicine have led to the development of many new and complex laboratory procedures. Many young physicians are tempted to dismiss a thorough clinical history and detailed physical examination as unnecessary or too time-consuming and substitute a battery of laboratory tests, often selected and performed without a personal contact with the clinical pathologist.

If the pathologist reviewing the results of such tests requests clinical data, he may receive this reply from one of the busy doctor's aides: "The doctor prefers to receive an objective laboratory report." This, in plain words, is pseudoscientific nonsense. One of the major medical responsibilities of the pathologist is to insure the adequacy and constancy of analytical values obtained in his laboratory.

All reputable clinical laboratories use extensive quality control systems in clinical chemistry, hematology, blood banking, serology and microbiology. The clinician should insist on it and he too should learn the range of variability and "confidence limits" (standard deviations) for a given test. How to interpret a value near the edge of the normal range? The pathologist and the clinician must develop a proper sense of clinical judgment in regard to the individual patient. Faulty interpretations, lack of knowledge of technical errors, range of quality controls established in that particular laboratory and undetected equipment failure may lead to disastrous results. Even tissue diagnosis requires in many cases—for maximum benefit to the patient—a knowledge of clinical and roentgenologic findings.

A few examples may illustrate these points:

For a correct diagnosis of many bone lesions, the correlation with clinical and roentgenologic data is indispensable.

The differential diagnosis between a benign keratoacanthoma and well differentiated squamous cell carcinoma is often extremely difficult, but knowledge of the rate of growth (rapid in keratoacanthoma) and the clinical appearance of the lesion will permit such a differentiation.

The interpretation of a lymph node showing atypical hyperplasia will be more valuable for the clinician if the pathologist is furnished information in regard to absence or presence of diffuse lymphadenopathy, splenomegaly, hematologic alterations and level of gamma globulin.

Electrophoresis of serum protein, a valuable clinical screening procedure, will permit rendition of a more useful report if the pathologist has the opportunity to correlate the electrophoretic pattern with clinical data of the individual patient.

The interpretation of uric acid levels has become more complex than in the past and elevated levels may occur in many pathologic states not related to classical gout.

Increasing hematologic abnormalities detectable in "routine" blood smears may furnish important clinical clues if examined with full knowledge of previous treatment with drugs, exposure to toxic agents or recent viral infections.

Bone marrow examinations are rendered much more meaningful if the pathologist is able to interpret the findings in the light of all clinical data.

A long list of such examples could be given but for the purpose of this article, these must suffice.

Only by utilization of the clinical pathologist as a true clinical consultant and not as a supertrained technician can the attending physician and his patient obtain maximum benefits from laboratory methods applied to clinical diagnosis and often avoid unnecessary, expensive and complex technical procedures.

We plan a new series of short talks on this Path-finder page dealing with selection and interpretation of laboratory tests in the light of given clinical data. Clinical and laboratory data will be given in concise, condensed form and negative findings will be omitted. This new series will appear under the title: "Differential Diagnosis of the Month." ◄

P.O. Box 1468
Terre Haute

## An Expression of Gratitude

The Indiana State Medical Association on behalf of all its members would like to express their gratitude to Eli Lilly and Company and to Smith Kline and French Laboratories for their generosity in replacing drugs destroyed in the Palm Sunday tornadoes which struck our state.

Eli Lilly and Company announced that they would replace all Lilly products destroyed in Indiana, Illinois, Ohio, Michigan and Wisconsin. Their offer includes both insured and uninsured drugs. Biologicals kept under refrigeration in areas where power failed long enough to possibly affect the drugs will also be replaced.

Smith Kline and French advised druggists in the disaster areas that they would replace all uninsured losses of their prescription products.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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# Army's New Field Hospital Demonstrated

THE NEW easily transportable field equipment of the U. S. Army Medical Department is designated by the achronym MUST (Medical Unit Self-Contained Transportable).

The equipment has gone through its experimental stages and has now been manufactured in pioneer quantities for field use and the further improvements which are sure to be indicated and implemented by actual use.

A recent public demonstration at Fort Sam Houston, Texas illustrated the capabilities of the new units and showed how all the advances of medicine and surgery may be made available almost routinely in forward positions in almost any type of terrain or weather.

Because of the transportability and adaptability of MUST, there were many civilian observers present at Fort Sam Houston to evaluate its use in remote areas, natural disasters and in civil defense.

MUST is especially adaptable for use as the Mobile Army Surgical Hospital. It provides this type of surgical and medical care to all situations in which it is difficult to provide conventional shelter and a fixed installation type of medical equipment. It is described by the Office of the Surgeon General as follows:

> The MUST unit consists of a combination expandable shelter shipping container, a ward-type inflatable shelter, and a self-contained utility system providing electric power, air conditioning, heating, hot and cold running water and waste water service. Its elements are compact, lightweight, easily moveable and by combining equipped functional elements can be assembled into the various types of field hospitals.
>
> The expandable container features modern facilities for performing the most complex and delicate surgical operations. It can fold into a compact package which serves as a shipping container and holds all equipment. It can be carried by a 2½ ton truck or mounted on detachable highway transporters for towing, is air transportable by cargo aircraft and can be moved by helicopter.
>
> The hospital ward container holds an inflatable ward shelter capable of providing intensive medical treatment for 20 combat casualties together with all basic hospital ward equipment. Two wards can be carried on a 2½ ton truck.
>
> The utility element weighing 3,600 pounds is designed around a gas turbine engine that can furnish 85 kilowatts of 400 cycle electric power generation. It also has the capability of furnishing 10 kilowatts of 60 cycle current and can maintain four ward elements or 11 surgical elements at a temperature of 65° F at -65° F ambient and at 80° F at 140° ambient. This unit will also provide ward element inflation air, hot and cold running water and

waste water disposal services.

The utility element, five feet, ten inches wide, eight feet, eight inches long, and seven feet, four inches high, also has storage space for air ducts, electric cables and water distribution hoses. When in transport, it is secured on a M-104 trailer or M-35 truck, and can be operated either on or off these vehicles.

Principal advantages of the system are that it will provide a world-wide operating capability under any environmental condition, improve medical treatment capability, allow maximum use of physicians' and nurses' skills and increase mobility of combat support units.

To increase the effectiveness of the various MUST elements under field conditions, equipment and parts have been standardized to make the most efficient use of space. Storage cabinets for example are the same in the surgery, laboratory and central material supply elements. Other standard items developed include folding work tables, a double sink unit and plastic "tote boxes" designed for storing and transporting supplies within the hospital. These boxes slide in and out of cabinets, stack without tipping and nest to conserve space.

An all-new operating table highlights the special equipment of the MUST's surgery element. Lightweight yet sturdy, the table adjusts to all nine standard surgical positions and has the unique feature of stability found before only in tables used in fixed medical installations. This stability is provided by its unusual base—a ballast tank filled with 100 pounds of water that can be drained or removed by vacuum when the table is transported. Complete with accessories, the table weighs less than 200 pounds. Folded for shipping, it forms a 28 X 28 X 23-inch package.

Illumination for the surgical field consists of a light that operates on 24 volts furnished by trickle-charged batteries. Each of the three four-source light heads delivers a minimum of 1,500 foot-candles at the surgical field. Ceiling-suspended from adjustable arms, the lights are mounted independently to illuminate more adequately one or more surgical sites, a common need during combat conditions. Due to the battery operation, there is no loss of surgical light if the normal electrical current is interrupted.

Other items specially designed for the MUST operating room include a single piece of equipment that serves a four-fold purpose as instrument stand, basin stand, backtable and kick bucket; and a double-basin scrub sink whose hot and cold running water facilities are controlled by knee mixing valves.

For the MUST laboratory, two special refrigerators were fashioned—one provides the controlled temperatures of the blood bank; the other the different temperature range required for biologicals. Electrical power is fed them during times of storage and transit as well as during operation. An emergency power source is also available to maintain refrigeration should the current fail.

It is difficult to see how this can be improved. In fact, it is difficult to comprehend how such compact and easily transportable equipment will be able to provide medical and surgical care which, at the present time, is probably not even available in all fixed hospitals.

# Frank B. Wynn, M.D.

EACH EXTENSION and elaboration of the educational potential of the medical scientific exhibit has served to extend and elaborate the honor which is due Dr. Frank B. Wynn for his pioneer work in establishing the scientific exhibit as a part of the scientific program of the annual convention of the American Medical Association.

It is possible, profitably, to spend the entire convention time in the scientific exhibits alone. In fact, it would be necessary to devote this much time to the task if the full educational potential of all the exhibits was to be realized by any one individual. New medical knowledge and graphic means of its presentation at the AMA exhibit often antedates its appearance in textbooks, and even in periodical literature.

The editorial below appeared in the March 15 issue of the *Journal of the American Medical Association* to announce Journal publication of suitable AMA exhibits and to acknowledge medicine's obligation to Frank B. Wynn, M.D. and Thomas G. Hull, Ph.D. for their monumental contributions to the art of medical education.

### Scientific Exhibits

"In 1899, a scientific exhibit was shown at an American Medical Association convention for the first time. Frank B. Wynn, M.D., of Indianapolis—a pathologist—exhibited more than 700 pathological specimens at the Columbus (Ohio) meeting.[1] The following year committees were

[1] Hull, T. G.: "Bureau of Exhibits," in Fishbein, M.: *History of American Medical Association* 1847 to 1947, Philadelphia: W. B. Saunders Co., 1947, p. 1042.

formed, the Section on Pathology was created, and a pathology exhibit was made a permanent feature of the annual meeting. In 1902 Wynn recommended broadening the scope of the exhibit to include all branches of medicine.[2]

"The enthusiastic reception of scientific exhibits at the turn of the century assured their appearance at subsequent conventions. Now such exhibits are a prominent feature at both the annual and clinical conventions of the AMA. Awards have been made to the originators of outstanding exhibits since 1908. For the past five years the award for the best scientific exhibit at the clinical convention, based on original research or instruction methods, has commemorated the name of Thomas G. Hull, Ph.D. honoring his 30 years' service in the Department of Scientific Assembly.

"Beginning in this issue of *The Journal* [*JAMA*] (p. 910) and continuing at intervals for approximately three months, we publish material derived from some of the exhibits displayed at the 18th annual clinical convention at Miami Beach, Fla., Nov. 28 to Dec. 2, 1964. The exhibits were chosen because they conform to a number of criteria set up by the editorial board, including scientific merit, the effective use of illustrative material, and the likelihood of effective presentation in *The Journal* [*JAMA*]. Each of the exhibits so treated deserves publication on its own merits. It is also the hope of the editors that publication of these picture-essays will promote further interest in an equally high standard of excellence for exhibits at future meetings."—Reprinted from *JAMA* 191:11, p. 139, March 15, 1965.

[2] Wynn, F. B.: Scientific Exhibit and Its Future, *JAMA* 40:350-352 (Feb. 7) 1903.

## Editorial Notes...

**Safe transfusions with blood stored for months and even years may be possible in the future.** A new quick-freezing process has been studied by the VA Hospital at Ann Arbor, and appears to be feasible and safe. The method involves the use of polyvinylpyrolidene (PVP) as a protector for the red cells. PVP does not have to be washed out of the blood before it is injected. An older freezing process used a cellulose as the protector, but had the disadvantage that the cellulose must be separated from the blood after thawing and before use. Total replacement transfusions have been done safely in monkeys by this new method. The VA has attained the distinction, by the research, of having the first hospital in the world with a monkey frozen blood bank.

**A bill to tighten controls over amphetamines and barbiturates has passed the House of Representatives by a vote of 402 to 0.** In two days of debate, there was no expression of opposition and only two amendments were adopted, one of which stiffened the penalties for sale or gift of the drugs to persons under 21 years of age without a valid prescription. At the time of House passage, it was predicted that the Senate would probably pass the bill without committee hearings. The bill had the support of the AMA, the Pharmaceutical Manufacturers Association and the American Trucking Association, as well as several associations of druggists.

**"The magnitude of coronary heart disease as a medical problem among men has tended to obscure the importance of this condition as a source of sickness and death among women."** The Statistical Bulletin of the Metropolitan Life Insurance Company reports that in 1963 this disease accounted for 212,000 deaths among females in the U.S., 60% more than the toll from cancer. Arteriosclerotic heart disease in women has increased sharply since 1950, and now accounts for 25% of female mortality.

**The VA reports further improvement of a prosthesis for above-knee amputees.** An oil-filled hydraulic system is used to control and monitor the knee movements on the new model, a great improvement over the old gravity and friction brake mechanism. The VA provides artificial limbs to about 10,000 above-knee amputees. There are about 100,000 other Americans who may benefit from the VA research.

**What to take on a quick trip around the world?** Space capsules carry two injectable drugs—Tigan for nausea (selected for its

minimal sedative effect) and Demerol for pain. Tigan is also carried in capsule form. Other oral medicines are Dexedrine, Demerol, Achromycin, an aspirin-phenacetin-caffeine combination and an anti-malarial, Aralen. All drugs are available in the in-flight kit and the survival kit, except that the anti-malarial is included only in the survival kit (no mosquitoes away out there). Water purification tablets are carried in the survival kit. An automatic injector is provided for the injectable drugs.

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**BCG, the tuberculosis vaccine, leads a double life—advocated for universal use in Europe and recommended for limited use among people in high risk and intimate exposure situations in the United States.** BCG is prepared as a live vaccine from an attenuated strain of bacilli of bovine origin. The organisms are presumably strong enough to induce an immune reaction but too weak to cause disease. It produces a positive tuberculin-test reaction and for that reason destroys the value of the test as a screening procedure. Expert opinion advocates its use here only in case of (1) children living in areas where the incidence in young people is high; (2) professional and other persons whose work involves a high risk of exposure; (3) persons unavoidably exposed to infectious cases in the home; and (4) inmates of institutions in which tuberculosis is prevalent.

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**Artificial kidney centers operated by the VA are now keeping 50 veterans alive who would otherwise have been dead as a result of kidney failure.** Four centers are now in action, three more are under construction and four are planned. The system in each case removes impurities by extracorporeal dialysis of the blood. Between 200 and 400 newly diagnosed patients are acquired each year, a fact which justifies expansion of the system to an ultimate 40 centers, each with a capacity of 10 to 20 patients. Research now seeks to improve the process and shorten the treatment time (now 10-16 hours per treatment).

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**An isotope-powered space engine is being developed by the Atomic Energy Commission.** A low-thrust rocket engine, powered with polonium-210, has been tested successfully in a ground laboratory in Ohio. The engine as now planned would be about 13 inches in length and four inches in diameter and would weigh about 30 pounds. It would produce one-fourth pound of thrust, which would be sufficient to propel a vehicle in space where gravitational forces would be minimal. It may also be useful for positioning space vehicles and for controlling attitude. The engine is far enough along to have acquired a name—"Poodle."

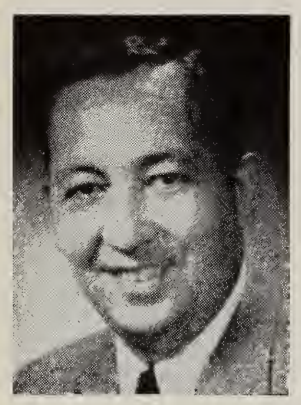
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**Indiana got the vote out in the last election:** 73.3% of the voting-age citizens of the state voted. This was 12.9% better than the national average and was exceeded by only four states. ◄

# President's Page

## *Junior-Senior Day*

The Indiana State Medical Association is well represented by its many commissions. The program for our future is dependent upon their ability and activity. They sponsor many individual activities and seminars which are certainly beneficial to our stature and our future.



Junior-Senior Day, sponsored by the Commission on Public Health, is an outstanding and growing affair. This year 250 physicians and their wives, juniors and seniors in medical school and their girl friends or wives participated in a workshop which was held at the Columbia Club. The format consisted of a presentation of the opportunity for practice and living in and outside urban communities.

Doctors are good speakers, entertainers and counselors. Drs. Lamb, Babb, Rifner, Petry, Neumann and myself presented a future for the practice in Indiana. My wife, Mary, advised the girls that life is worth living and very satisfying as a physician's wife in smaller communities. A panel answered many questions, from the value of an electronic answering service to group practice to a wife's role on the medical team.

The day culminated in a social hour and banquet sponsored by Mead Johnson and Blue Shield. Mr. Frank Woolley presented organized medicine's stand on legislation and its need for diligent efforts in the political arena. Mr. Woolley's remarks were well appreciated and enthusiastically received by the students. His banquet consultations lasted into the wee hours.

We, as an association, are grateful for the help of Blue Shield and Mead Johnson in sponsoring our participation in this program. Thanks! Thanks also to the Public Health Commission, Blue Shield and Mead Johnson for a great day for our future.



Recommended Dosage of Lomotil Liquid to Control Diarrhea

File: Diarrhea

# LOMOTIL®

| Age | INITIAL LOMOTIL LIQUID DOSAGE* |
|---|---|
| 3-6 mo. | ½ tsp. t.i.d. (3 mg.) |
| 6-12 mo. | ½ tsp. q.i.d. (4 mg.) |
| 1-2 yr. | ½ tsp. 5 times daily (5 mg.) |
| 2-5 yr. | 1 tsp. t.i.d. (6 mg.) |
| 5-8 yr. | 1 tsp. q.i.d. (8 mg.) |
| 8-12 yr. | 1 tsp. 5 times daily (10 mg.) |
| **Adult** | 2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.) |

*Based on 4 cc. per average teaspoonful.
**Note:** After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

## LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride (Warning: May be habit forming) ..... 2.5 mg.
atropine sulfate ..... 0.025 mg.

**Precautions**
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

**Cautions and Side Effects**
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

# The Woman's Auxiliary

## REPORTS TO ISMA

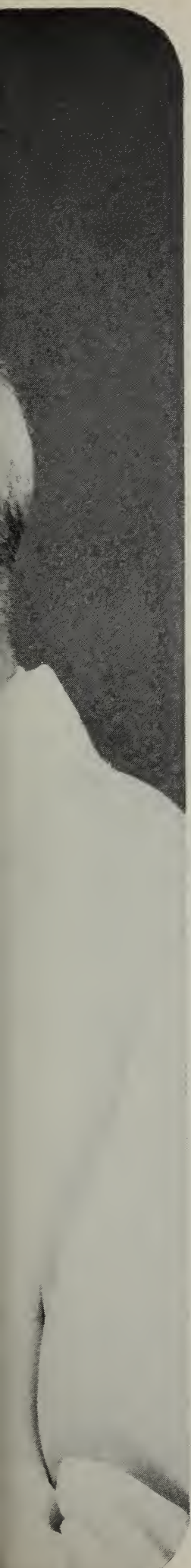
The culmination of a most successful year with a House of Delegates meeting in April brings us to another beginning that is actually a continuation. With a new slate of officers and chairman assuming duties, plans are being made to attend the Woman's Auxiliary to the American Medical Association in New York June 20th to 24th. It is our hope to have a fine representation of wives attending with their husbands.



A new method of getting material to the grass roots has been announced by the National Board of the Woman's Auxiliary to the American Medical Association. They have approved the publication of a direct communication to county auxiliary presidents to be called the *Direct Line*. The first issue will be mailed as soon as possible after the convention in New York and will contain a simplified digest of national committee programs.

The state president, and president-elect and chairmen will also receive this new service. The hope is that each county auxiliary, with definitive material in hand early in the summer, will be better equipped to plan the coming year. There has always been a problem in incorporating national's recommendations when material arrives in the fall. Our programs can now be current and more effective.

Ruth V. Dunstone



# There are few "nots" in Miltown therapy

- **Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.**
- **The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.**

**Indications:** 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

**Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

**Precautions:** Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Usual adult dosage:** One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

**Supplied:** In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

*Before prescribing, consult package circular.*

## Miltown® (meprobamate)

WALLACE LABORATORIES / *Cranbury, N.J.*

CM-4534

# Physician-Hospital Relations*

HOWARD W. DOAN, M.D.†
Chicago, Ill.

I HAVE BEEN with the American Medical Association since September 1 of this year. Since that time, I have been exposed to a concentrated dose of medical staff organization, physician-hospital relations, legal aspects of medical staff function, medical staff bylaws, rules and regulations, medical audits and many other matters which come under the study of the Department of Hospitals and Medical Facilities, of which I am director.

Now, if I have pulled any solid facts from this deluge they are that the physician is the typical figure around which all medical care circulates, and that medicine is a real profession — one of very few. I read just recently, and for the life of me I can't remember where, this definition of a profession, and I quote:

> "A profession is a calling requiring specialized knowledge and adherence to a code of ethics by its participants who themselves accept responsibility to police their profession and to insure the quality of service its members render. And it will not surrender those responsibilities to any third party."

I think you'll agree that this is a fine statement, and one that we can subscribe to.

In the *Report on Physician-Hospital Relations,* published by the Council on Medical Service of the American Medical Association, the following is found, and I quote again:

> "The medical profession and the hospitals, cognizant of a growing interdependence, [have] voluntarily collaborated in instituting a system of 'self-government' providing for an organized, departmentalized medical staff, with specific lines of authority and areas of responsibilities under an officer and committee structure, all designed to achieve and maintain high standards of medical care. Such voluntary controls have proved adequate when effectively applied. However, survey findings and third party comments stress that voluntary controls are not being uniformly applied and that, in fact, many medical staffs are not functioning properly."[1]

Dr. Edwin L. Crosby, president of the National Health Council, concluded in a talk last September before the National Voluntary Health Conference:

> "Let me say that voluntary organizations cannot remain voluntary unless they are free of . . . controls. Let me also say that they cannot remain voluntary unless they are responsible. This, as you clearly recognize, requires that voluntary organizations must establish their own effective controls. The two words, 'freedom' and 'responsibility' convey what I mean. These words are not antithetical but complementary. To be responsible, a voluntary organiza- must be free: to be free, it must also be responsible."[2]

Now there's much concern, and by thinking people, that our voluntary institutions will not long remain so, and there's worry as to what can be done about it.

### Rules and Regulations

Adequate motivation for the establishment of good medical staff organization exists in abundance. It may be in the interest of the patient's care and his economics, or it may be in the doctor's and hospital's

* Speech given before the Indiana State Society of Internists, Dec. 5, 1964, at Indianapolis.

† Director of the Department of Hospitals and Medical Facilities of the American Medical Association.

[1] *Report on Physician-Hospital Relations,* Committee on Medical Facilities, Council on Medical Service, American Medical Association, June, 1964, p. 26.

[2] Crosby, Edwin: "Vital Issues in Voluntarism as Seen by the National Health Council." Speech before the National Voluntary Health Conference, Chicago, Illinois, September 17-18, 1964.

desire for freedom of action and self-government. It may be a matter of pride in service. But whatever it is, every staff should recognize that without well-identified motivation, what should be an easy, pleasant chore becomes a painful process. Most doctors, I think, assume rather perfunctorily that bylaws of a medical staff are reasonable and natural parts of our society. In many quarters there appears to be doubt on this point. But let me rather flat-footedly confirm that a medical staff must have its bylaws. Maybe I'm bringing coals to Newcastle in discussing this subject, but I think it's important.

Why bylaws? The answer is simple. The medical staff of a hospital is a group of individuals, and as a group, lives in a society governed by laws and not by whims of men. There are rules for every game. We can take a leaf from the book of baseball here. You will note that no matter how many times the visiting team may have played in that particular ball park — it may even be the second game of a double header — the managers and the umpires gather at home plate just before the game starts, and they go over the ground rules. They can't make rules after the game has started.

During times of tranquillity, with everything going smoothly and according to Hoyle, there's no need to wave the bylaws, rules and regulations around. But you can't begin to make them up only when the problem of the unethical physician, the alcoholic, the drug addict, the uncooperative or the incompetent arises.

Probably the single most important reason for having an organized, disciplined medical staff is because it is here, within the medical staff, that quality standards are maintained. There is little or no knowledgeable control elsewhere. We're proud of the high standard of medical care in the United States, and the physician who judges his fellows and allows them to judge him has made this standard possible. Mutual judgment and respectful acceptance of judgment are the marks of a professional — the stamp of sterling on silver.

There are other reasons for self-determination. One was stated most lucidly in a question put to me by Dr. Michael. What's the best approach for us as physicians to be able to remain in command of patient care? I assume this is patient care in the broadest possible sense, because where the individual patient is concerned, there is usually little difficulty. I also assume, and this from the tenor of the other questions asked, that the chief difficulties arise because of controls or restrictions established by hospital governing boards.

### United We Stand . . .

Strong influence can be brought to bear by the medical staff of any hospital only when it is organized and functioning as a team rather than as a bunch of strong-willed individuals, each going his own sweet way. We in medicine have a reputation for being especially strong-willed. We're supposed to be a bunch of rugged individualists. I say, Fine! If we weren't, just imagine the sheep-like qualities of character in charge of the nation's health. But there are times when we must unite and present one face to the world. I can't imagine a governing board ignoring the views of its medical staff when that staff presents a united front and backs its recommendations with sound reasons therefor. To do so would be courting disaster.

We are often asked about physician membership on governing boards. There is no moral reason why physicians shouldn't sit on hospital governing boards. And I believe there is no legal bar in any but one or two states. It should be remembered, however, that physician members are not there to represent the medical staff. There are other and far better mechanisms that serve this purpose. They are there, as are the other members, as civic-minded, responsible members of the community. It is true their medical backgrounds will enable them to contribute technical opinions and advice when indicated, but the basic reason for their presence does not rest on their professional knowledge.

A member of a governing board has one and only one vote, and as a voting member, he's usually accorded just that much consideration and esteem. However, when the president of the medical staff or the chief of staff or the chairman of the executive committee submits an opinion or a recommendation, he should have the massed

weight of the entire medical staff behind him. Most governing boards listen very, very carefully, but once the board has outvoted its medical member, it makes it just that much more difficult for the staff to cause a reversal.

Twelve years ago, in 1952, one of the most significant organizations in the health field was organized. The American College of Physicians, the College of Surgeons, the American Hospital Association and the American Medical Association got together and agreed to organize, sponsor, and finance a Joint Commission on Accreditation of Hospitals, and take over the job which the College of Surgeons had started in the 1920's. This commission of 20 members — 17 of them are doctors — is governed primarily by doctors of medicine, and all its hospital surveyors are physicians.

There has been criticism. This is sometimes difficult to understand when we remember that the standards are formulated by doctors seeking to improve the quality of patient care, and that the request for survey is a voluntary request on the part of a hospital. At any rate, at the end of 1963, 4,027 of the 7,138 hospitals registered by the American Hospital Association were accredited. This is 64% of all hospitals listed. Of the short-term hospitals, the more typical community-type hospital, the percentage is higher, standing at 85%. Here again is the stamp of sterling on silver.

The Joint Commission has been likened to a mirror on the wall in which we see reflected our professional image. But if we look closely, we can see others looking at us even as we look at ourselves. Public sophistication about health and medical care has grown rapidly in the past decade and the public watches our activities from many angles. Breaking this mirror will not stop public scrutiny. Thoughtful physicians realize we need better mirrors — the more accurately to reflect all phases of medical care and hospital service.

### Hospital Planning — Good or Bad?

I would like to mention voluntary areawide planning of hospitals and health facilities. The AMA became interested several years ago as a result of an increasing number of inquiries from local societies asking what their role should be in areawide planning programs, and what guidance the AMA could furnish. The House of Delegates is on record as favoring voluntary planning, but it is opposed to any mandatory requirements imposed thereon by government. It also recommends the medical profession's full participation in voluntary planning programs. I think I can make the following statement categorically: if we don't do it, somebody else will.

Certainly, no one can object to the orderly, the rational and proper distribution of medical facilities, and this implies planning — careful planning.

Now when does a voluntary organization become a non-voluntary one? I'm told that in one community, a request for an advance of funds from the Federal Housing Agency by the developers of a nursing home was sent back without action. This community had a voluntary planning agency in which the medical profession was well represented. The FHA told the developers to resubmit their request when this local planning agency had reviewed the proposal and arrived at a recommendation.

Well, someone said, the agency had become a Trojan Horse, and another said, well, isn't that better than getting the go-ahead or the turn-down from some clerk in the Federal Housing Agency?

There are arguments against areawide planning, and they're made by sincere and thoughtful individuals. These arguments are based on the premise that usually planning of any sort, whether it be governmental or voluntary, eliminates the law of supply and demand, and every American is entitled to venture into business. He has the right to succeed; he also has the right to fail. A violation of either of these rights is a blow to the free enterprise system.

Now, what about this free enterprise business? Free enterprise operates with private risk capital. The great bulk of hospitals in this country today do not do so. They enjoy tax-exempt status and are public or private non-profit institutions. Fewer than three percent of all the hospital beds in America are operated by proprietary interests for profit, and 97% enjoy tax-free status. They are not operated as business for profit under a free enterprise system.

A second argument often advanced is that planning will eliminate competition; that the person with the "better mouse trap" won't be able to merchandise it; that hospitals through competition are forced to make improvements. The people who give this argument say that government requires free competition in most businesses because it means lower prices to the consumer. Why should hospitals be excluded?

Well, why should they? If American Air Lines puts in first-run movies for its passengers, United better do it too. If Community Hospital buys a heart-lung machine or a cobalt bomb, should Memorial buy them too? An artificial kidney? Hyperbaric chamber? Is this the kind of competition we want? We want all the cobalt machines and artificial kidneys in a community that it needs, but more than this is wasteful duplication and adds another straw to whose back — the back of the patient. As a profession, don't we reject this concept of competition?

Now, as to beds, certainly we stand for the number of beds a community needs and can support, but the effect of overexpansion of hospital beds on per diem rates in any community is devastating. It also has a deleterious effect on hospital administration. When a hospital is under severe economic pressure to keep up the occupancy rate, its staff lacks incentive to regulate admissions, to press for shortened stays or to tighten discharge procedures.

Those who argue against planning reject the premise that government will do this planning if we don't on the basis that we're not defeatists — yet. They say we must elect legislators and executives who are for and not against free enterprise. Well, I can't argue with that. But free enterprise must not become a golden calf. We must try always to do what is best for the individual, the community, the state and the country. Oversupply does not serve any of these well.

### Now a Public Arena

We've heard a great deal in recent years about physician-hospital relations. What is this all about? Have there been difficulties? Of course there have, but in the main, physicians and hospitals are working better together, and more closely together, than ever before.

This had to be. The hospital is assuming ever greater importance in the broad field of medical care. It owes to the physicians of its staff an organizational environment in which medical practice of high quality is possible. Preferably, this will be an environment in which minimal standards can be exceeded rather than merely met. And, in providing these facilities, it should also offer the opportunity for the medical staff to become involved in the planning and in the efforts toward attainment of mutual goals.

The physician as a doctor should have only one interest — his patients. But as a staff member, as an organization member, this interest should be properly broadened to all patients, to programs of education and research, to problems of funding and cost, to organizational and related hospital activities. In other words, medical staffs must be considered an integral part of the administrative team of the hospital.

Dr. Russell Nelson, Director of Johns Hopkins Hospital, and presently a member of AMA's Committee on Medical Activities, and a former president of the American Hospital Association, stated in the October, 1961 issue of the *Journal of the American Hospital Association*, and I quote: "It is . . . high time that medical staffs be brought more closely into the hospital team, with more responsibility, more participation and more authority."[3]

Not too long ago, hospitals were used by physicians as private workshops to which they admitted their patients and worked in complete autonomy and in a highly privileged atmosphere. Today, thanks to education and the news media and to the medical profession itself, the physician's private workshop has become a public arena. More people know, and talk about, what's going on in hospitals and particularly in "their" hospital. The $80,000 cobalt machine is good newspaper copy which attracts either criticism or approbation from the readers. The use of Enovid brings forth emotional outbursts from the laity, rang-

[3] Nelson, Russell A.: "The Physician and the Hospital," *J.A.H.A.*, 35:44-47, October 16, 1961.

ing from high enthusiasm to complete denunciation. And hospital costs! This we hear about from many, many angles.

Hospitals are changing. Patterns of use are changing. Hospital outpatient clinics have long suffered from their inheritance of the stigmatized label, "charity dispensary." Resources have been generally inadequate, staffing uncertain and unreliable, services fragmentary and impersonal. This old order is changing. One of the big switches in recent years has been that large numbers of the public are turning from the doctor's office to the hospital emergency room.

Why? We're trying to find out. You are probably all aware that the great majority of cases seen in emergency rooms are not emergent. We have begun a study of emergency room utilization, and we've come up with some answers which, though early and as yet statistically unsound, do serve as indicators. Shortage of family physicians, the nomadic nature of large segments of our population, medical irresponsibility on the part of many families. These and many more have been advanced as causes. We want to find out who the people are who use these facilities, and above all, why they present themselves at the emergency room. Who sends them? We're looking into staffing patterns across the country, methods of charging for emergency room visits, ways to educate the public about the true function of the emergency room, and public relations programs to encourage the proper use of these facilities.

### The High Cost of Illness

Much concern has been expressed in the past few years over the upward trend in hospital costs. Government, management, labor, state insurance commissioners, and the general public have voiced this concern, and with justification. And so has organized medicine. Recently, one hospital authority stated that per diem costs of $80 and more can be expected in a few years. And there appears to be an attitude of resignation and inevitability on the part of many leaders in this field which gives one pause. Must this be?

Without question, the cost of shopping in

Continued

**Hygroton®**
**brand of chlorthalidone**

**the long-acting diuretic**

**Indications:** Many types of edema involving retention of salt and water.
**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.
**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
**Average Dosage:** One tablet (100 mg.) daily with breakfast.
**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Swartz, C., et al.: Circulation 28:1042, 1963.

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# Representative Harvey Opposes Medicare

**Statement of the Hon. Ralph Harvey, (R-Ind.) on the floor of the U.S. House of Representatives during the consideration of H.R. 6675, the Administration's "medicare" bill.)**

Although I stand opposed to H.R. 6675, the Administration's "medicare" bill, I would like to point out that this does not mean that I am unmindful of the problems that prompted this legislation in the first place. Rather, my concern is with how best these problems can be solved. Through *compulsory* payroll tax deductions for everybody under Social Security, the authors of "medicare" say that the public interest will best be served. I cannot agree with this.

The Republican alternative actually offers a more comprehensive program of medical insurance, financed partly by premium contributions and by the general revenue tax system based on ability to pay. Under the provisions of King-Anderson, all people 65 and over would be eligible for benefits. The Republican program is *voluntary*, thereby reducing appreciably the costly duplication of coverage. The King-Anderson measure takes everyone 65 and over and makes them "wards of the state" insofar as hospital benefits are concerned.

To me this is not only an insult to the American people, but lacking in understanding. The senior citizens of this country want to be independent and, above all else, they do not want to be a burden on the working men and women of this nation. The proposal offered by the Republican leadership will enable these people to make small contributions, which they themselves are willing to do to keep their independent status.

Pollsters have stated that over three-fourths of the total civilian population, and 60% of the aged population, had some form of private health insurance as of December 31, 1962, and that there is reason to predict that senior citizens' participation in private health insurance programs will increase appreciably in the years ahead. It would seem to me that King-Anderson goes too far. Actuarial experts have projected that a young man entering the work force will have paid into the Social Security fund a staggering amount of money by the time he reaches 65. Had this money been invested privately and interest accrued, the total figure is slightly over $38,000. Hardly an insignificant sum.

Insurance companies in the United States have stated a willingness to offer more comprehensive coverage for less cost. While it is true that the Administration's bill does have a voluntary enrollment provision whereby for a small monthly premium doctor's and related services will be paid, the Republican proposal, at no extra charge, covers cases of a catastrophic nature as well as doctor's fees and drugs. Last but certainly not least, among my objections are the cost estimates of the program under Social Security. I do not believe that even the experts actually know just how much this program is going to cost the American taxpayers.

Having recognized the importance and need for constructive legislation in this field, in January of this year I reintroduced a bill to provide a *completely voluntary* medical care insurance program. I introduced similar proposals in the 87th and 88th Congresses. It *does not* require action by state legislatures. It contains no "means test." It is based upon a completely confidential relationship between each individual and the Treasury Department, the health insurance carrier of choice, the doctor and the hospital. It does not discriminate. It is a true free enterprise plan to help Americans take care of themselves.

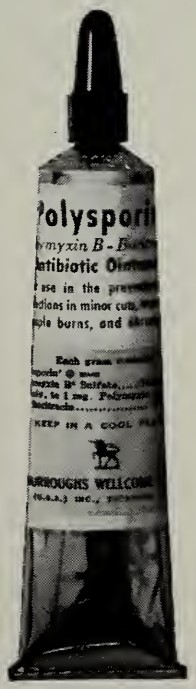
Under the provisions of the Harvey Bill every American who is 65 or over would file a Federal income tax return whether or not he owed any tax. A simple, easy-to-file return is recommended. If an individual or a married couple owed no tax, the Treasury

Department would give a Medical Care Insurance Certificate. The certificate could be used to obtain the kind of medical care insurance the citizen desired. The insurance carrier, in turn, would receive payment of the premium cost, up to $150 per person, by presenting the certificate to the Treasury. Also in this regard I think it is noteworthy to mention that there is a growing trend in the United States toward the purchase of health insurance for retired employees by former employers. The Harvey Bill encourages this practice by offering the same $150 credit to the employer who provides health insurance for retired employees.

As of March, 1965, 40 states and four territories have initiated the legislative authority for implementation of the Kerr-Mills program of medical assistance for the aged who are recipients of old-age assistance. My proposal is intended as a supplement to the Kerr-Mills Law and other programs which assist in medical care for senior citizens. To a great degree, the provisions in the Harvey measure would replace the other programs. There would be approximately 14.5 million Americans over 65 who would be eligible for benefits. Maximum possible cost of the program would be 14.5 million multiplied by $150. This figure would be reduced somewhat by several factors, including: (1) the amount spent by the government under other programs would be reduced appreciably, and (2) there would be a displacement of most income tax deductions now claimed for illnesses.

First full-year cost estimates under King-Anderson are 2.3 billion. Under the Harvey Bill, first full-year cost estimates predict $1 ¼ billion. This amount, however, would not appear as an additional appropriation but rather as a reduction in the general revenue. By comparison of the two programs and the effect the King-Anderson Bill will have on the economy and the Social Security program, I invite my colleagues to join me in opposing this ill-conceived legislation. ◄


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*Medicine At Law*

# DECISIONS AND OPINIONS

**Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.**

*Doctor not Required to Use Extreme Precautions*—A patient was not entitled to recover damages in a suit against the government, under the Federal Tort Claims Act, for damages allegedly caused by the negligence of a doctor in a Veterans Administration hospital in the performance of a well recognized medical procedure known in rare instances to have serious side effects, where the evidence established that the doctor followed the usual practice and used the usual degree of skill of medical men in his field of practice in the community, if not indeed elsewhere throughout the country, the U.S. Court of Appeals for the First Circuit ruled. Although the doctor might perhaps have used more extreme precautions in performing the procedure, a preliminary clinical examination of the patient disclosed no need for them.

*Correia v. U.S.*, 339 F. 2d 596 (C. A. 1, Dec. 30, 1964)

*Original Tortfeasor Succeeds to Injured Person's Medical Negligence Claim When Given Release*—The insurer of a driver who was at fault in an automobile accident, settled the claim of a man for injuries received in that accident, which injuries were allegedly aggravated by the negligence of a hospital, a doctor, and a nurse in treating them, and received a release from the injured man that did not contain a reservation of the malpractice cause of action. By doing so, the insurer succeeded, by right of subrogation, to his cause of action against the hospital, doctor and nurse, the Wisconsin Supreme Court ruled. However, it would be against sound public policy, the court said, to allow the injured man to acquire by assignment from the insurer a right to recover damages in addition to the amount received from the insurer in settlement of his claim, which amount was the fixed value of his entire cause of action including the negligence of the hospital, doctor, and nurse.

*Hartley v. St. Francis Hospital*, 130 N.W. 2d 1 (Wis., Sept. 2, 1964).

*State Liable for Suicide of Mental Hospital Patient*—The administrator of the estate of a mental hospital patient who committed suicide was entitled to recover damages in a suit against the state, where the evidence established that the hospital had notice of the patient's suicidal tendencies, even though there had been no adjudication that he was incompetent or insane, a New York intermediate appellate court ruled.

The patient was placed in the hospital after his arrest for the alleged murder of his wife, in order that a finding might be made as to his sanity at the time of the crime and his mental competence to stand trial. The hospital's records clearly showed that it had knowledge of his suicidal tendencies, and he was placed in seclusion with full precautions against suicide. The patient committed suicide on the third day of his hospitalization by tying an ace bandage, furnished by the hospital, around his neck and pulling at the ends of it with such force that he strangled himself.

Since the hospital had notice of the patient's suicidal tendencies, a duty arose at the time of his admission to use ordinary and reasonable care to prevent his suicide. The hospital's duty to the patient was not suspended pending a finding of his sanity or insanity in accordance with some legal definition. The combination of the hos-

pital's knowledge of the patient's suicidal tendencies and its failure to properly supervise him while his sanity was in doubt made the state liable for his death under well-established principles of negligence law, including the important element of foreseeability, the court said.

*Gioia v. State of New York,* 254 N. Y. S. 2d 384 (N. Y., Dec. 10, 1964).

*No Liability in Connection with Diagnosis and Treatment of Internal Bleeding*—A patient was not entitled to recover damages in a suit against the government, under the Federal Tort Claims Act, for injuries allegedly caused by negligence on the part of doctors at a Veterans Administration hospital in diagnosing and treating his condition, where the evidence established that the doctors exercised ordinary care in their diagnosis and treatment of the patient, who was critically ill with obscure symptoms, including internal bleeding, a federal trial court ruled.

The patient was admitted to the VA hospital complaining of pains in the gastric area, vomiting blood and passing blood-stained stools. Transfusions were administered and every effort was made medically to stop his bleeding.

The next night, after the patient began to bleed massively, a gastric resection was performed. The cause of the bleeding was not discovered during the operation, no abnormalities of the esophagus or vessels were noted, but the spleen was found to be enlarged and the stomach moderately distended.

A short time after the operation the patient again developed severe bleeding. At that time he had recuperated sufficiently to make possible the taking of proper x-rays and other medical tests, which could not be taken when he was admitted to the hospital because of his critical condition. On the basis of the information gained from these tests, the patient's spleen was removed and a spleno-renal shunt performed. No esophageal or upper gastric bleeding had occurred since this operation.

The patient was critically ill and his symptoms, including the internal bleeding, were obscure, and the stomach resection was performed because of his massive bleeding. The doctors used ordinary care and judgment in their diagnostic procedures and their conclusions derived from their procedures. A wrong or mistaken diagnosis is not proof of negligence and there is no liability therefor, particularly in a case such as this where the symptoms were obscure, the court said.

*Pearce v. U.S.,* 236 F. Supp. 431 (D.C., Okla., Dec. 7, 1964).

*Doctor not Liable for Dropped Lower Lip After Plastic Surgery*—A patient whose lower lip was in a dropped position as the result of an infection that developed in the area of her mouth following plastic surgery to repair the grotesque appearance from which she suffered after the removal of a cancerous tumor from the left side of her face and neck was not entitled to recover damages in a suit against the doctor who performed the plastic surgery. The plastic surgery was successful except for the dropped lip.

*Ferrazzatti v. Mayne,* Cir. Ct., Cook Co., Docket No. 58S4635 (Ill., Feb. 8, 1965). ◄


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# Blue Shield and the Medical Profession

*(One of a series prepared by Blue Shield)*

Of the more than 1,800 organizations providing health care insurance protection in the United States to over 145 million Americans (77% of the population)—one is approved by the medical profession.

The one medically approved organization, Blue Shield, covers 26.41% of the United States population, providing over 34% of the medical-surgical prepayment protection in this country.

One of the primary reasons for this widespread acceptance of Blue Shield by the American people is that Blue Shield is under the direction of, and responsible to, the medical profession. Blue Shield is often referred to as "the doctor's plan" because all 84 Blue Shield plans in the United States, Canada, Puerto Rico and Jamaica are approved and guided by their local medical society. In fact, local medical society approval is required for a plan to use the Blue Shield name.

The first Blue Shield plan was organized by the medical profession in 1939, 25 years ago, when insurance companies claimed that underwriting health care protection was unfeasible. Doctors, recognizing the financial and emotional strain that unexpected medical expenses put upon the physical well-being of their patients, had to find a method to soften the impact of these expenses.

In the early years, the insurance companies' warning that health insurance underwriting was unfeasible seemed all too realistic. Too many dollars were paid out in relation to income received. By trial and error, physician trustees of early Blue Shield plans were able to put the plans on the sound actuarial basis that exists today.

Blue Shield succeeded in the face of dire warnings because medicine was behind it. The medical profession acted as the underwriter as well as sponsor of the Blue Shield plans.

Physicians from all parts of the country have given incalculable hours of their valuable time, without remuneration, as the directors and trustees of Blue Shield plans.

Did doctors accept these responsibilities in order to put medicine "in the insurance business?" Evidence points to an emphatic *no!* Medicine is in the business of providing medical care — nothing else. Doctors are concerned with the ways and means by which patients pay for medical care. It is in keeping with this "service to mankind" concept of medicine that doctors concern themselves not only with dispensing medical care . . . but also with making sure that those availing themselves of that care are not financially burdened by it.

The fact that the physician, the one most closely concerned with administering medical care, is also involved in administering the prepayment mechanism for that care, is of inestimable value to the Blue Shield member requiring care. The patient has the reassurance that the same careful attention which the doctor gives him is also given by the doctor to his Blue Shield prepayment mechanism. The patient knows that his Blue Shield membership, backed by the medical profession, assures him of the greatest possible benefits, at the least possible cost.

Blue Shield is "the doctor's plan," not in the sense that the doctor owns it, but because he created it, because the medical profession supports Blue Shield, because the doctor is responsible for the success or failure of it and because Blue Shield is the most impressive evidence medicine has ever given that it is capable not only of providing good service but of helping people pay for it. ◄

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## ABSTRACTS

## BOOK REVIEWS

### BRAIN—THYROID RELATIONSHIPS

Ciba Foundation Study Group No. 18, edited by M. Cameron and M. O'Connor, Little, Brown & Co., Boston, 1964, 117 pages, $1.95.

Weighing almost an ounce, the thyroid is one of the larger endocrine glands. Its function as a stimulator of metabolism has been familiar to many generations of physicians. I. P. Pavlov speculated on the relationship of thyroid and *mind.* We are aware of the existence of a thyrotropic hormone and the fact of a thyroxin ($T_4$) feed-back mechanism acting on the thalamic centers from whence the pituitary (and other centers) are regulated. Many years ago, a great clinician called the thyroid, "the gas pedal of the body."

Psychiatrists have been very diligent in preaching the rather grim fact that many inmates of mental institutions are really cases of overlooked "Myxedema madness": extreme *hypo*thyroidism producing chronic cerebral anoxia and thusly so impairing mentation that the patient is restrained rather than treated with thyroid.

In the last decade, we have started to look for the *precise* anatomic sites and the precise steric formulae of the compounds that are at the physical base of the end results visible to the clinicians. This study group represents a very crowded afternoon in the day of the experts grappling with the problems clamoring for a solution. The median eminence of the thalamus has a substance that might be called the thyrotropic-releasing factor. Is it really there? Can we get it in pure form so that we are able to sketch it in its chemical formula? This has just been done with a messenger RNA for alanine. What is the correlation with the body's thermic centers? How does it tie in with the reticular system and how do the impulses flow to the cerebral cortical areas determining the "affect?" *Why* and *how* is the thyroid hormone so absolutely indispensable to the fetus and the neonate?

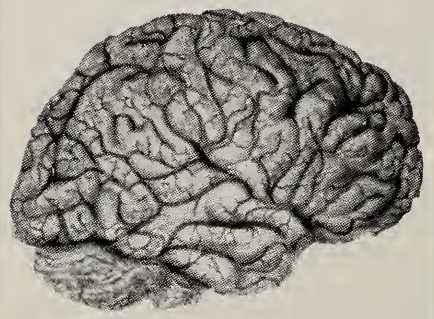
We are so complacent about the tremendous advances in so many expanding frontiers that we fail to appreciate the "blood, toil, sweat and tears" that go into the laborious studies making such progress possible. Twenty or even ten years from now, we shall have comparable study groups giving the next generation the questions now being only adumbrated.

The present study is strictly for the experts cogitating on the complexities of the tasks facing them. Until the answers are forthcoming, we must perforce be satisfied with a beginning statement of the mysteries facing us.

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New York, N. Y.


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where ischemia causes pain, spasm, ache, intermittent claudication; also coldness, numbness or ulcerati
of extremities.

## DRUGS OF CHOICE: 1964-1965

Edited by Walter Modell, C. V. Mosby Company, St. Louis, Missouri, 1964, 1018 pp., $16.75.

Each edition of this work has been a timely contribution to medical treatment in view of the vast number of new pharmaceutical preparations that have been put on the market in the past decade. Although this rapid production of new products has been presently restrained by the more stringent regulations of the Federal Drug Administration, prompted by the distribution of some harmful, inadequately tested drugs. The drug industry is so highly competitive and salesmanship so aggressive that the average physician is bewildered and often misinformed regarding the efficacy of new preparations.

This large volume — over 1000 pages — is the fourth edition of a work which has appeared every two years since 1958. The 47 contributors represent the various disciplines of medicine and are connected with some of the leading medical institutions.

The book is divided into 41 chapters and there are 45 tables. Each chapter takes up a particular clinical condition and discusses in detail the choice drugs for the particular disorders and also the preferred route of administration and dosage. The format of the book is ingeniously devised and adds greatly to its usefulness. There is a comprehensive index at the end of the book, and also at the beginning of each chapter is an index of the material presented in the chapter which adds greatly to the book's quick reference value. Also at the end of text material, is a drug index (119 pages printed on tinted paper for ready reference). The drug index lists the name of the drug, the manufacturer and the form in which it is dispensed. In this index are all new drugs that have had sufficient time to be tested and have proven to be of value. Some older drugs are not included because they are not considered to be of value and some newer drugs have not been tested sufficiently to be included. At the end of each chapter there is a short list of selected references.

The first chapter "Principles of Choice of Drugs and Application of Clinical Pharmacology" gives in some detail the complex methodology of laboratory and clinical evaluation of drugs. A vast amount of information is presented in this chapter which is interesting and important but rarely available to the practicing physician. It gives an idea of the improved methods of drug testing and points out the chemical relationships of drugs to their clinical use and possible side-reactions. Such information is not usually offered by the manufacturer or salesman who stress only the superiority of their particular products.

The last chapter of the text "Drugs for the Treatment of Poisoning" presents much quickly available and important information. Here are presented several pages of the clinical manifesta-

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tions of overdosage of potent drugs and their antidotes.

This work makes an excellent companion book to the *Physicians' Desk Reference.* Every physician should have access to this valuable work, and it is an excellent reference work for the training of houseofficers and students, because there is an alarming lack of authentic and impartial information concerning drug therapy in medical teaching. Every medical school and hospital library should have a copy, and not only every general practitioner and internist, but every specialist would do well to have a copy in his office.

DAVID A. BICKEL, M.D.
South Bend

## Abstracts From Various Literature, Prepared by AMA

### LEGAL ASPECTS IN THE EMPLOYMENT OF THE CARDIAC PATIENT

J. V. Thornton (522 Fifth Ave., New York)
*J. Occup. Med.* 6:405-408, (Oct.), 1964.

There is an increasing tendency to award Workmen's Compensation benefits for cardiac attacks. These awards are made on the theory that the attack was an accident arising out of and in the course of employment. Because of this, the threat of Workmen's Compensation claims is a significant factor in the hesitation of companies to hire cardiacs. The author turns to second-injury laws—an area where progress is feasible—to encourage employment of the cardiac. Actually, in over half the states, there are no second-injury laws that apply to cardiac cases. If second-injury laws are to be of real benefit in the cardiac field, they must be amended to eliminate the limitations that now restrict their coverage. Furthermore, it is important that the people in the personnel department are made aware of the existence of second-injury laws and their benefits. It is also desirable that compensation statutes in various states be amended to provide specifically that the medical treatment and care which the carrier or employer must provide includes medical and vocational rehabilitation. Finally, it is desirable that there be statutory machinery under which the compensation commission is explicitly empowered to make periodic reviews of the rehabilitation treatment.

### THE FREQUENCY OF MEALS: ITS RELATION TO OVERWEIGHT HYPERCHOLESTEROLEMIA, AND DECREASED GLUCOSE TOLERANCE

P. Fabry et al. (Institute of Human Nutrition, Prague, Czechoslovakia)
*Lancet* 2:614, (Sept. 19.), 1964.

In Prague, 440 men, aged 60 to 64, were selected at random to represent the male population of that age group in an urban district, and they were grouped according to the frequency of food intake. Sixty-one were excluded mainly because of diabetes, peptic ulcer and gastrectomy. Excessive weight, increased serum-cholesterol and diminished glucose-tolerance were all significantly commoner among those who took three meals a day (or less) than among those who took five meals (or more). The triceps and sub-scapular skinfold thickness were also significantly greater in the group consuming three meals or less a day. Men consuming three to four meals, with or without additional snacks, showed intermediate values.

### ORAL CATION EXCHANGE RESINS FOR TREATMENT OF AMMONIA INTOXICATION

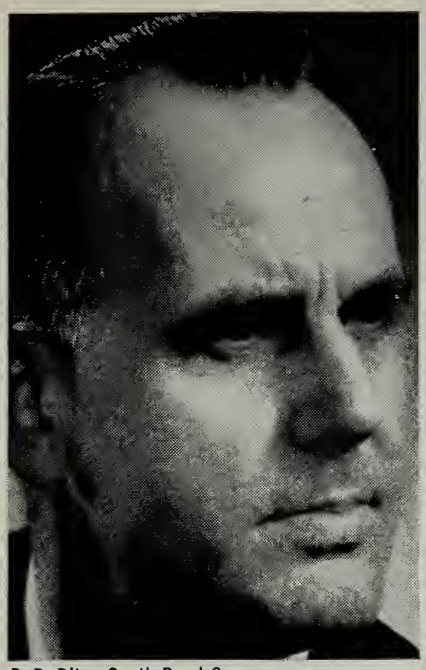
G. D. Zuidema et al. (University of Michigan Medical School, Ann Arbor)
*Surg. Gynec. Obstet.* 119:790-798 (Oct.), 1964.

The usefulness of orally administered cation exchange resins for controlling blood ammonia was explored. Twelve patients were treated during 17 episodes of hepatic coma. Eight patients responded well to resin therapy during 12 episodes of exogenous ammonia intoxication. None of the five patients with advanced chronic hepatic disease and failure showed significant clinical improvement, although blood ammonia levels were controlled in four of the five patients. Without exhibiting specific toxicity, exchange resins have rapidity of action and the ability to remove ammonia directly from the blood. However, the use of exchange resins in patients with endogenous ammonia intoxication was disappointing. Although it was possible to lower blood levels of ammonia, the coma was progressive and unremitting. This finding supports the possibility that factors other than ammonia contribute to the disintegration.

### RUPTURE OF THE TRACHEA AND RIGHT BRONCHUS AFTER AN ANESTHETIC EXPLOSION

P. Marchand (22 Kotze St., Johannesburg, South Africa), F. Reid, and H. van Hasselt
*Lancet* 2:1096 (Nov. 21), 1964.

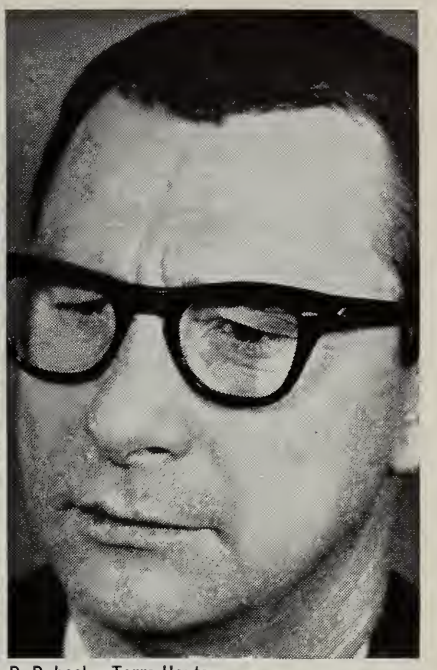
During routine tonsillectomy an explosion occurred after the use of diathermy while ether was being given. The tracheal membrane was avulsed from the tracheal cartilages on the right side extending from the circoid cartilage to the right main bronchus. The tear passed into the intercartilaginous space at the origin of the right upper lobe bronchus partially encircling, but not completely detaching it. Parenchymal and interstitial damage was minimal. The cervical trachea was repaired through a tracheostomy opening and the rest of the laceration was closed through the right chest. The patient is well two and a half years later. The findings of this case are compared with those of six other cases of ruptured trachea and bronchus. It is concluded that the effect of an explosive increase of intrabronchial pressure is to avulse the tracheal and bronchial membrane from the cartilaginous rings. ◄



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## I.U. FOUNDATION NAMES EUGENE N. BEESLEY TO DIRECTORSHIP

Eugene N. Beesley, president of Eli Lilly and Company, has been elected to the board of directors of the Indiana University Foundation.

Mr. Beesley, along with the 21 other members of the board headed by Herman B. Wells, will be responsible for receiving and administering gifts, bequests and grants for the benefit of the university.

The Indiana University Foundation announced last November that the Alumni Association of the I.U. School of Medicine had established an I.U. School of Medicine Fund, under the chairmanship of Dr. D. S. Megenhardt. 1965 has been designated as Van Nuys Memorial Year in honor of the late Dean John D. Van Nuys. Alumni and friends who wish to contribute to this fund or who require further information should contact Indiana University Foundation, Memorial Union Building, Bloomington, Ind.

## *American Medical Society of Vienna Aids Visiting English-Speaking Doctors*

The American Medical Society of Vienna was founded in 1879 with the purpose of facilitating contact and arranging postgraduate medical courses for visiting English-speaking physicians. It was reorganized in 1953.

An enormous variety of courses is offered in the University of Vienna and in the over 52 major hospitals in Vienna. All the clinical specialties and many of the basic sciences are covered. All instruction is in the form of seminars, grand rounds, round table discussions and practical sessions of patient examination and treatment. No lecture courses are given as such.

The American Medical Society of Vienna maintains a headquarters at the University with every possible amenity available to the visiting doctor. Complete information may be obtained by writing the Secretary of the American Medical Society of Vienna, Universitaets-strasse 11, Vienna 1, Austria, or by writing Dr. William K. Rock, 1125 W. Fourth St., Waterloo, Iowa 50702. A listing of the Seminar Congresses may be obtained by writing Gausepohl Travel Service, 321 N. Pennsylvania St., Indianapolis 46204.

## Dr. DeVault Named Representative

Dr. Virgil T. (Jack) DeVault, a graduate of Indiana University School of Medicine in 1929, has become the American Medical Association's first international field representative.

Dr. DeVault has practiced surgery in several locations in South America and in this country. He was recently the medical director of the Foreign Service and Department of State in Washington, and holds a commission in the U. S. Public Health Service. His duties will concern liaison with the medical profession in foreign countries.

## *Flying Physicians Association Offers No Dues Membership to Students*

The Flying Physicians Association has announced that medical students may belong to the association at no cost; interns and residents will be charged $5.00 annual dues. In announcing this policy, the board said that heretofore, members in this category had been charged the regular $20.00 yearly membership.

Headquarters of the Flying Physicians Association is 332 S. Michigan Avenue, Chicago.

## Lt. Gen. Heaton Named Surgeon General of the Army Again

Lt. Gen. Leonard Heaton has been retained for the second time past the normal four-year tenure as Surgeon General of the Army. His original appointment would have expired in May 1963, but was extended for two years by President Kennedy.

President Johnson has further extended his term to December 1, 1966. This is unprecedented in modern times, and is a compliment to his many professional and administrative talents.

## *Camping for Crippled Children Available June 27-August 6*

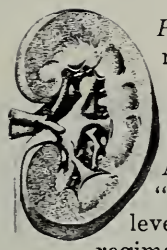
Camping for crippled children will be provided this summer at Camp Riley in Bradford Woods near Martinsville by the James Whitcomb Riley Memorial Association.

Complete details and application forms may be obtained by writing the Association at 129 E. Market St., Indianapolis 46204.

## Dr. Porterfield Appointed

Dr. John D. Porterfield, III, onetime Deputy Surgeon General of the U. S. Public Health Service, and most recently, Coordinator of Medical and Health Sciences, University of California has been

# One antibiotic superior to Tetracycline Chloramphenicol Streptomycin Kanamycin Polymyxin B Penicillin G against Proteus mirabilis and E. coli



*Proteus mirabilis* is not only the most common cause of *Proteus* infections of the urinary tract, but such infections are often resistant to other antibiotics.[1-4] According to Anderson *et al.*,[5] "When assessed in terms of serum levels attainable with usual dosage regimens, ampicillin was the most effective drug tested against *E. coli* and *P. mirabilis*." These authors found *Klebsiella-Aerobacter* and *Pseudomonas* organisms relatively insusceptible to ampicillin. With its broad-spectrum coverage of many gram-positive and gram-negative bacteria, absence of toxicity, and slow emergence of resistant strains, PENBRITIN (ampicillin) is a most beneficial and safe drug in treating urinary tract infections—*killing* the pathogens, not just suppressing them.

*Dosage:* Adults—500 mg. every six hours (higher doses may be required for severe infections). Children—(under 13 years, whose weight will not result in a dosage higher than that recommended for adults) 100 mg./Kg./day in divided doses every six or eight hours for moderately severe infections; 200 mg./Kg./day in divided doses every six hours for severe infections.

*Contraindications:* (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms. *Aerobacter aerogenes*, *Pseudomonas pyocyanea*, and *Proteus morganii* are resistant to PENBRITIN (ampicillin).

*Side Effects:* Mild effects, such as skin rashes, diarrhea, nausea and vomiting, have occasionally appeared.

*Precautions:* As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

*Supplied:* No. 606—Each capsule contains 250 mg. of ampicillin. Bottles of 16 and 100.

*References:* 1. Hanson, R. J., *et al.*: J. Urol. *79*:1016 (July) 1958. 2. Middletown, J. E.: Brit. M. J. *ii*:497 (Aug. 31) 1957. 3. Today's Drugs, Brit. M. J. *i*:1475 (May 26) 1962. 4. Brumfitt, W., *et al.*: Lancet *i*:130 (Jan. 20) 1962. 5. Anderson, K. N., *et al.*: J.A.M.A. *187*:87 (Feb. 22) 1964.

## Kills bacteria—does not just suppress them

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appointed to and has accepted the directorship of the Joint Commission on Accreditation of Hospitals. He succeeds Dr. Kenneth Babcock who resigned in April, 1964.

## *Book and Pamphlet on Mental Retardation Available from AMA*

Copies in book and pamphlet form of the material on mental retardation which appeared in the January 18 issue of *JAMA* are now available.

"Mental Retardation — A Handbook for the Primary Physician" is a 139-page paperback book and "Who Helps the Physician Help the Retarded?" is an illustrated pamphlet. A single copy of each may be obtained without charge by any physician who requests copies by writing on his own letterhead to the AMA at 535 N. Dearborn, Chicago 60610.

## R. S. Saylor Elected Vice-President of National Assn. of Blue Shield Plans

R. S. Saylor, executive vice-president of Indiana Blue Shield, was elected vice-president of the National Association of Blue Shield Plans, at the association's annual business meeting in San Francisco. The association is the coordinating agency for the 85 Blue Shield plans in the United States, Canada, Puerto Rico and Jamaica.

Saylor entered the Blue Shield movement in 1943 with the Wisconsin Blue Shield Plan. He came to Indianapolis in 1946 when the Indiana State Medical Association formed the Indiana Blue Shield plan, and has served as executive vice-president of the Indiana plan since that time.

## Ohio Names New Executive Secretary

Mr. Hart F. Page has been appointed Executive Secretary of the Ohio State Medical Association following the retirement of Mr. George H. Saville.

Prior to assuming his new position, Mr. Page served the association as director of public relations and assistant executive secretary. He was also in charge of the association's Rural Health program at one time.

## *Full Program Planned For Children Of AMA Members at New York Meeting*

A day at the World's Fair, tours of New York's historic and mid-town sections and special evening entertainment are included in the program planned for children of AMA members attending the annual convention in New York, June 20-24.

Because of the number of children expected, reservations must be made before June 8. For full details write to Gulliver's Trails, 25 Central Park West, New York, N. Y. 10023. ◄



**DR. MAX NORRIS discusses the Indiana Explorer Scout program with Mr. William H. Spurgeon III as Dr. Douglas White and Mr. Richard Zapapas look on. Spurgeon, who was the principal founder of Special Interest Exploring in 1956, spoke at a recent meeting in the Indianapolis Athletic Club.**



**PANEL MEMBERS** who answered questions of junior and senior medical students at the Saturday, March 27 Junior-Senior Day meeting, held at the Columbia Club were (left to right standing) Dr. T. Neal Petry, Delphi; Dr. Forrest J. Babb, Stockwell, program chairman; Dr. Eugene S. Rifner, Van Buren; and Mrs. Joe Black, Seymour. The practice of medicine in small communities was emphasized at the meeting and general practitioners from throughout Indiana discussed the subject with the students.


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# Field trials of the SCHWARZ STRAIN live measles vaccine have demonstrated an efficacy of 97% to 100%[1-8]

# and, because it is highly attenuated,

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Lirugen is the highly attenuated, but fully antigenic, live virus measles vaccine (Schwarz Strain). Additional special passages of the Edmonston Strain resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed.

Early field trials[1-6] established that a single injection of Lirugen produced significant levels of measles antibody and protection in 97% to 100% of susceptible children. Reactions to the vaccine were minimal. A mild, febrile response, when it occurred, was generally of very short duration. In more recent clinical trials, Lirugen was administered to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported.[7, 8] Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. Temperature above 103° (rectally) occurred in less than 3% of the inoculated group and above 104° (rectally) in only 0.5%. The incidence of mild, transient rash attributable to the vaccine could be calculated at 2.88%. No other symptoms in the inoculated group were markedly more frequent or severe than similar symptoms in the control group.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.

**Administration:** A single subcutaneous injection of 0.5 cc. for active immunization of children 9 months of age or older against measles (rubeola).

**Supplied** in one dose packages containing vial of lyophilized vaccine, cartridge of sterile diluent, and sterile, disposable syringe and needle.

**References:**


**1.** Schwarz, A. J. F.: Preliminary Tests of a Highly Attenuated Measles Vaccine. Amer. J. Dis. Child., **103:** 386-389, 1962.

**2.** Krugman, S., Giles, J. P., Jacobs, A. M., and Friedman, H.: Studies with a Further Attenuated Live Measles-Virus Vaccine. Pediatrics, **31:** 919-928, 1962.

**3.** Andelman, S. L., Schwarz, A., Andelman, M. B., and Zackler, J.: Experimental Vaccination against Measles. Clinical Evaluation of a Highly Attenuated Live Measles Vaccine. J. A. M. A., **184:** 721-723, 1963.

**4.** Measles Vaccines: Report of a WHO Scientific Group, W. H. O. Technical Report Series No. 263, 1963.

**5.** Schwarz, A. J. F.: Immunization against Measles: Development and Evaluation of a Highly Attenuated Live Measles Vaccine. Annales Paediatrici, **202:** 241-253, 1964.

**6.** Morley, D. C. et al., Measles and Measles Vaccination in an African Village Bull. W. H. O., **30:** 733-739, 1964.

**7.** Andelman, S. L., Schwarz, A., Andelman, M. B., and Spiegelblatt, H.: Field trials with further-attenuated live measles vaccine (Schwarz Strain) without gamma globulin. Scientific exhibit at annual meeting of The American Academy of Pediatrics, 1964.

**8.** Unpublished data.



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# *Annual Meeting Dates of Professional Medical and Allied Organizations*

**AMERICAN MEDICAL ASSOCIATION CONVENTION**
Date June 20-24, 1965
Place New York, N. Y.

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date May 3-5, 1966
Place Fort Wayne

**BONE AND JOINT CLUB**
Date October 13
Place The Athenaeum, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 19, 1965
Place Indianapolis

**INDIANA STATE SOCIETY OF ANESTHESIOLOGISTS**
Date May 15, 1965
Place Indianapolis Athletic Club

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

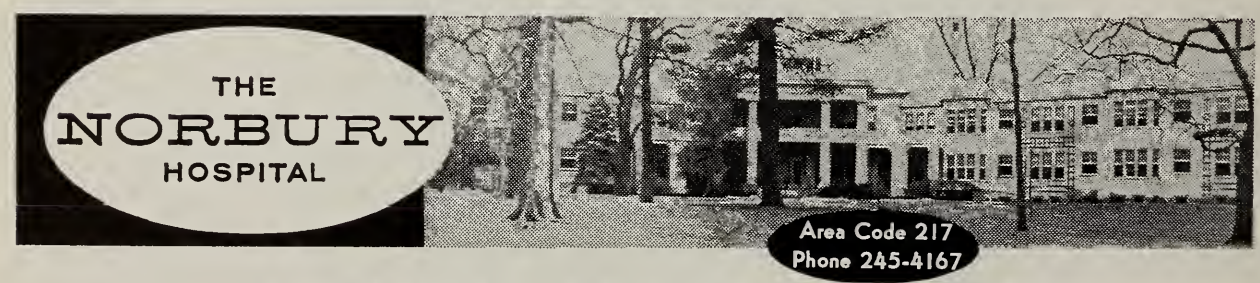
**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 12-14, 1965
Place Murat Temple, Indianapolis

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

**INDIANA ORTHOPAEDIC SOCIETY**
Date June 25-26, 1965
Place Marott Hotel, Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


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# FUTURE MEETINGS, SEMINARS, COURSES

## *Rocky Mountain Cancer Conference Will Hold 19th Meeting in July*

The Rocky Mountain Cancer Conference will conduct its 19th meeting on July 16 and 17, at the Brown Palace Hotel, Denver.

Morning symposia for the two-day session will deal with "Practical Chemotherapy in Cancer" and "Malignant Lesions of the Colon." The afternoon sessions will be devoted to scientific papers by guest speakers on the first afternoon and an "Information Please" session scheduled for the second afternoon. Authorities from all over the U. S. will participate. For further information write Rocky Mountain Cancer Conference, 1809 E. 18th Ave., Denver 80218.

## American Ob-Gyn Board Sets Part I (Written) Examination

The next scheduled Part I (written) examination of this board will be held at various examining centers in the United States, Canada, and military bases outside of the continental United States on Friday, July 2, at 2:00 p.m.

New and reopened applications and requests for re-examination in the Part II examination for 1966 will be accepted in the office of the secretary during April and May, 1965. Candidates are reminded that duplicate lists of patients dismissed from their service during the 12 months immediately preceding April 1, 1965 must accompany application or request to take the Part II examination.

Current bulletins outlining present requirements and application forms may be obtained by writing to the office of the secretary, Clyde L. Randall, M.D., American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

## *Seventh Annual AMA-ASHA Session On School Health set for June 20*

The seventh annual AMA-ASHA preconvention session on School Health will be held June 20 in conjunction with the AMA annual convention in New York City.

All physicians interested in school health programs are invited as well as educators, nurses, dentists and other related professionals. For additional information, write Department of Community Health and Health Education, American Medical Association, 535 N. Dearborn St., Chicago 60610.

## World Medical Association To Meet in London in September

The World Medical Association will meet in London from September 19 to 25. The Association has grown tremendously since it last met in London in 1949 in its fourth year of existence.

The six-day meeting will be complete with a scientific program oriented around "Communicable Diseases and Modern Travel." Social events are planned for all and a special ladies program has been arranged. Information on observer credentials, accommodations, individual and group travel, medical tours and sightseeing is available from the United States Committee, WMA, 10 Columbus Circle, New York City 10019.

## *SMA Section of Ophthalmology Schedules November Meeting*

The Section of Ophthalmology of the Southern Medical Association will meet in Houston, Texas on November 1 to 4, 1965.

Papers are being accepted from now until May 15. A title and brief abstract should be sent to Dr. George S. Ellis, 812 Maison Blanche Bldg., New Orleans 70116.

## The American Fracture Association Lists Dates of Future Meetings

The American Fracture Association cordially invites all physicians who are interested in various types of fracture treatment to attend the annual meeting to be held at the Riviera Hotel in Las Vegas, Nevada, October 24 to 28.

The American Fracture Association, whose membership includes physicians from North, Latin and South America, is the only organization which limits its entire programs to the treatment of fractures by various methods.

In 1966 the annual meeting will be held in Caracas, Venezuela, November 1 to 5, and in 1967 will be held at the Sheraton-Chicago Hotel in Chicago, Illinois, October 28 to November 2.

All physicians interested contact Dr. H. W. Wellmerling, Secretary General, 610 Griesheim Building, Bloomington, Ill. ◄


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# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—March, 1965

| Disease | Mar. 1965 | Feb. 1965 | Jan. 1965 | Mar. 1964 | Mar. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 608 | 329 | 283 | 427 | 421 |
| Chickenpox | 681 | 743 | 890 | 835 | 786 |
| Conjunctivitis | 155 | 116 | 139 | 151 | 94 |
| Diphtheria | 1 | 0 | 1 | 0 | 2 |
| Dysentery, Unspecified | 155 | 29 | 42 | 61 | 95 |
| Gonorrhea | 299 | 267 | 319 | 279 | Not Available |
| Impetigo | 130 | 100 | 103 | 134 | 74 |
| Infectious Hepatitis | 57 | 70 | 29 | 53 | 62 |
| Infectious Mononucleosis | 94 | 94 | 40 | 41 | 41 |
| Influenza | 5945 | 1301 | 612 | 818 | 16934 |
| Measles (Rubeola-Rubella) | 755 | 320 | 209 | 4541 | 847 |
| Meningitis, Meningococcal | 10 | 4 | 5 | 8 | 3 |
| Meningitis, Other | 11 | 9 | 3 | 5 | 10 |
| Mumps | 413 | 335 | 324 | 1047 | 381 |
| Pertussis | 7 | 32 | 28 | 26 | 37 |
| Pneumonia | 756 | 299 | 291 | 157 | 501 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 0 |
| Streptococcal Infection | 817 | 753 | 577 | 766 | 325 |
| Syphilis | | | | | |
| Primary & Secondary | 2 | 9 | 3 | 3 | Not Available |
| All Other Syphilis | 94 | 80 | 90 | 101 | Not Available |
| Tinea Capitis | 20 | 9 | 30 | 20 | 6 |
| Tuberculosis (Active) | 134 | 87 | 86 | 114 | 106 |


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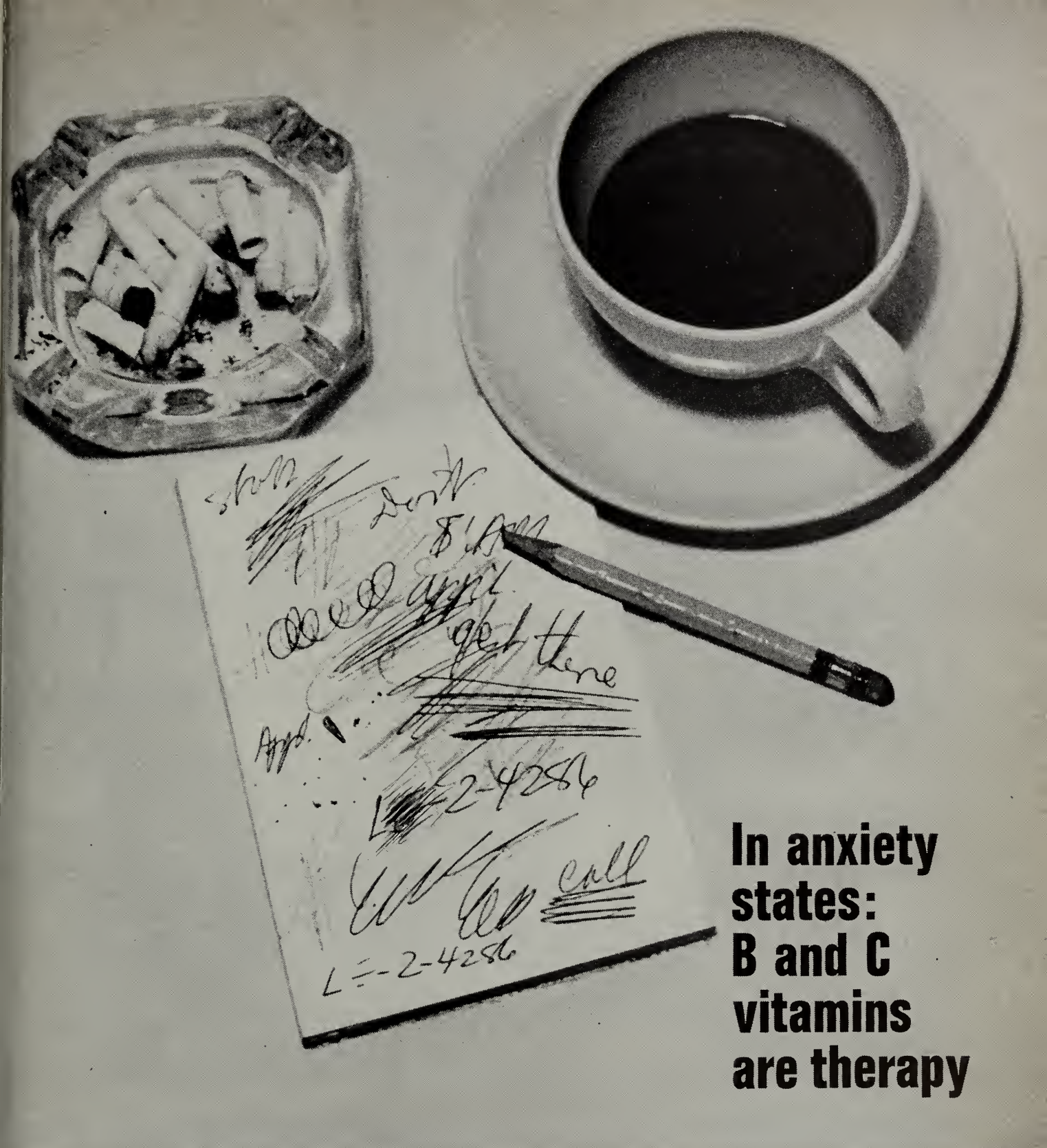



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| Niacinamide | 100 mg. |
| Vitamin C (Ascorbic Acid) | 300 mg. |
| Vitamin $B_6$ (Pyridoxine HCl) | 2 mg. |
| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
| Calcium Pantothenate | 20 mg. |

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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# County News

## Adams

Dr. Robert L. Boze, Berne, and Dr. John E. Doan, Decatur, have been re-elected president and secretary-treasurer, respectively, of the Adams County Medical Society.

## Carroll

Dr. T. Neal Petry, Delphi, discussed the general practice review meeting he attended in Denver at the March 17 meeting of the Carroll County Medical Society.

## Cass

"Preoperative Care" was the topic chosen by Dr. Harry D. Brickley, Indianapolis surgeon, when he spoke before the April 5 meeting of the Cass County Medical Society.

## Clark

Robert Amick, ISMA Field Secretary, reported on the state legislature at the March 16 meeting of the Clark County Medical Society. There were 23 members present.

## Clay

Dr. James B. Johnson, of Greencastle, spoke before the March 16 meeting of the Clay County Medical Society. Eight members were present.

## Daviess-Martin

The ISMA preceptorship program and its success in Daviess-Martin counties was discussed at the March 15 meeting of the medical society. Fifteen members attended.

## Dearborn-Ohio

Dr. J. Kenneth Jackson, Aurora, gave a history of the local county society as read from old minutes before the March 4 meeting of the Dearborn-Ohio County Medical Society.

## Decatur

Nine members of the Decatur County Medical Society met March 19 with Field Secretary Amick to discuss the state legislature and the secretary's trip to Washington.

## Elkhart

An expert from Standard and Poor spoke on "Investments and Securities" before the March 4 meeting of the Elkhart County Medical Society.

## Grant

Dr. Jere D. Guin, Kokomo, discussed "The Adverse Effects of Sunlight on the Skin" with the 43 members of the Grant County Medical Society present at the March 23 meeting.

## Hancock

"Scrotal Lesions" was the topic of Dr. C. J. Van Tassel when he spoke at the March 22 meeting of the Hancock County Medical Society. Eleven members attended.

## LaPorte

Dr. Richard W. Stander, professor of obstetrics at Indiana University School of Medicine, spoke on "Erythroblastosis" at the March 16 meeting of the LaPorte County Medical Society. Fifty members attended the meeting.

## Madison

Dr. W. K. Patterson has been elected president of the Madison County Medical Society; Dr. W. L. Baughn, vice-president and Dr. D. G. Jones, secretary-treasurer. All of the new officers are from Anderson. Drs. W. A. Laudeman, Elwood, and R. D. Williams, Markleville, were elected delegates.

## Montgomery

New hospital plans were the main topic of discussion at the March 18 meeting of the Montgomery County Medical Society.

## Morgan

Dr. Edgar Kourany, Mooresville, has been named secretary-treasurer of the Morgan County Medical Society.

## Porter

The Porter County Medical Society met with Field Secretary Howard Grindstaff March 30 to discuss national and state legislation.

## Pulaski

Dr. Henry R. Eshleman, Monterey, has been elected president of the Pulaski County Medical Society.

## Shelby

The Shelby County Medical Society met March 3 to hear Dr. William Deupree speak on "Current Immunization Procedures and Recommendations."

## Starke

New officers of the Starke County Medical Society are: Drs. Earl R. Leinbach, Hamlet, president; Clark McClure, Knox, vice-president; W. Allen Palmer, Knox, secretary-treasurer and Guy B. Ingwell and Dr. McClure, delegates.

## Vanderburgh

Dr. Joseph C. Lawrence reported on his recent trip to the Western Conference on Foundations for Medical Care at the March 16 meeting of the Vanderburgh County Medical Society.

### Wells

A movie of the 113th annual AMA convention was shown as part of the program at the March 15 meeting of the Wells County Medical Society. Thirteen members attended.

### Whitley

Dr. David Sorg of the Bluffton Clinic spoke on "Thyroid Disease" at the March 9 meeting of the Whitley County Medical Society. Ten members were present. ◄


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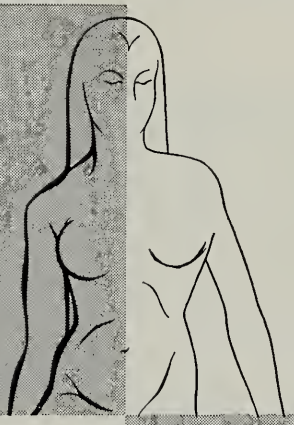
J. W. Gibbs, M.D. Associate Medical Director



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# Deaths

## Charles A. Ballard, M.D.

Dr. Charles A. Ballard, 81, Cass County health officer and a physician in Logansport for 58 years, passed away April 4 at Logansport.

Dr. Ballard was born at Logansport and after being graduated from the University of Illinois Medical School in 1907, he returned there and entered the medical practice of his father. He was a member of the ISMA 50-Year Club and the Cass County Medical Society.

## Colonel G. Mackey, M.D.

Dr. Colonel G. Mackey, staff member of Logansport State Hospital for 10 years, died March 17 at Logansport. He was 74.

Dr. Mackey, who practiced at Culver for 35 years before joining the Logansport Hospital staff, was graduated from the I.U. School of Medicine in 1915. He was a member of the Cass County Medical Society and the ISMA 50-Year Club.

## Grover L. Verplank, M.D.

Dr. Grover L. Verplank, 77, who retired two years ago after practicing medicine more than 50 years, died March 31 at Gary.

Dr. Verplank was graduated from the University of Michigan Medical College in 1911. Records show that he delivered approximately 6,000 babies in Gary, probably more than any physician there. He was chairman of the Mercy and Methodist Hospital obstetrics and gynecology departments for several years. Dr. Verplank was a member of the Lake County Medical Society and the ISMA 50-Year Club. ◄

## SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 12-14, 1965, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

_____

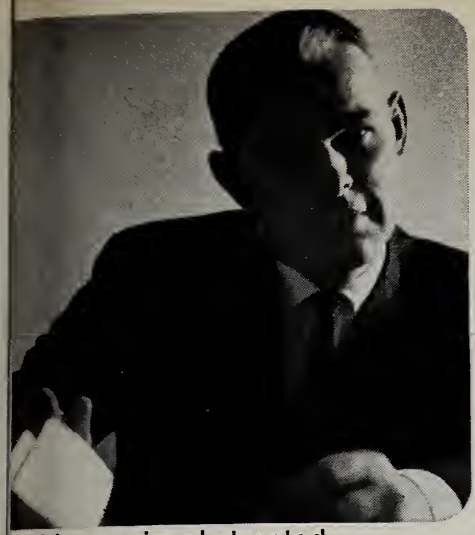
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Name_____

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State_____



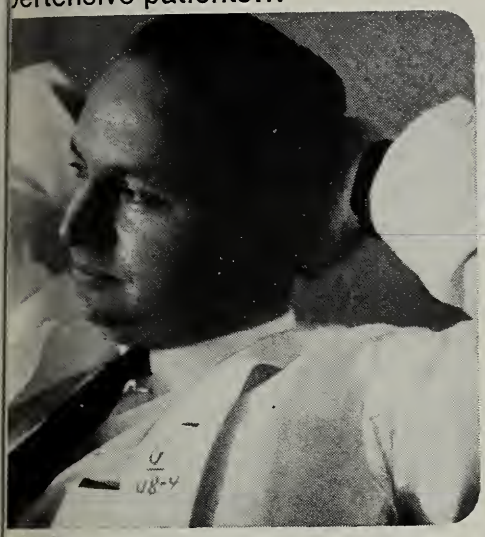
and in previously treated
pertensive patients...



Uh-huh.



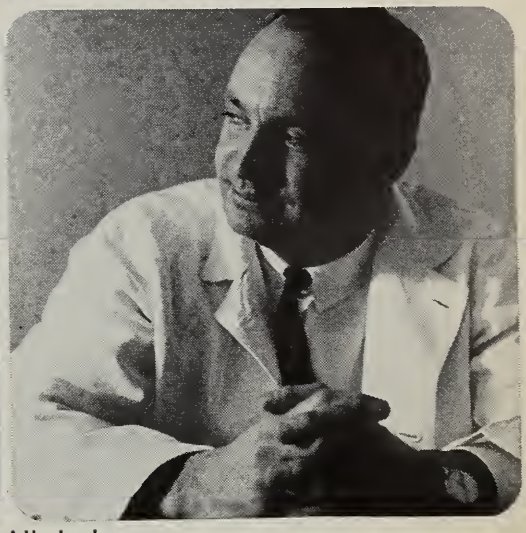
Regroton improved response
in 76 out of 80...



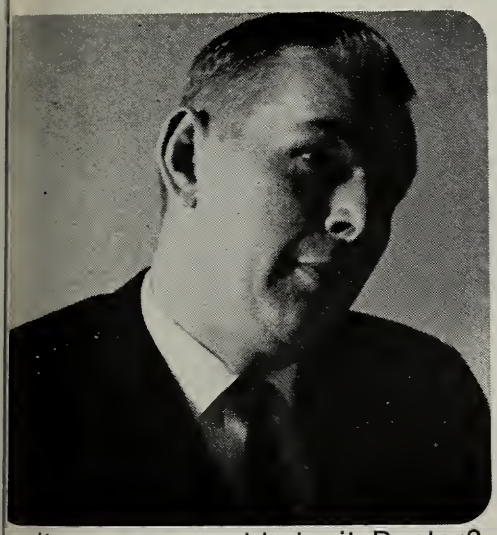
-huh.



...reducing mean arterial pressure
from 135 to 112 mm. Hg.



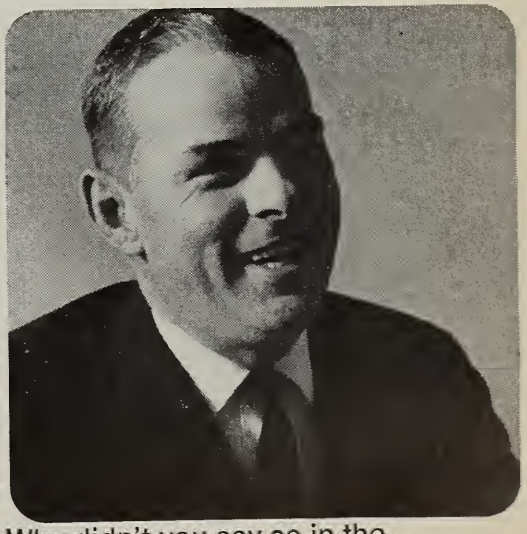
Uh-huh.



on't you even want to try it, Doctor?



I've *already* got eleven patients
doing fine on Regroton.



Why didn't you say so in the
first place?

# Regroton®

Superior to other antihypertensives in 76 of 80 patients in a 2-year study*

# Geigy

*omposition:* Each tablet contains chlorthalidone, 0 mg., and reserpine, 0.25 mg.
*ontraindications:* History of mental depression, ypersensitivity, and most cases of severe renal r hepatic diseases.
*Varning:* Discontinue 2 weeks before general nesthesia, 1 week before electroshock therapy, nd if depression or peptic ulcer occurs.
*recautions:* Reduce dosage of concomitant anti-ypertensive agents by one-half. Discontinue if he BUN rises or liver dysfunction is aggravated. lectrolyte imbalance and potassium depletion ay occur; take particular care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended. Use with caution in patients with ulcerative colitis, gallstones, or bronchial asthma.
*Side Effects:* Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.
For full details, see the complete prescribing information.

*Average Dosage:* One tablet daily with breakfast.
*Availability:* Bottles of 100 and 1000 tablets.

*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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Division of Geigy Chemical Corporation
Ardsley, New York

RE-3455

# Association News

## EXECUTIVE COMMITTEE

April 3, 1965

Present: Ralph V. Everly, M.D., chairman; G. O. Larson. M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* J. A. Waggener, executive secretary.

### Membership Report

| | |
|---|---|
| Number of members as of December 31, 1964 | 4,365 |
| 1965 members as of March 31, 1965 | 4,186* |
| Number of members as of March 31, 1964 | 4,176 |
| Gain over last year | 10 |
| Number of AMA members as of March 31, 1965 | 4,092 |
| Total 1964 AMA members as of March 31, 1964 | 4,060 |
| Gain over last year | 32 |
| 1965 AMA members: Dues paying | 3,605 |
| Exempt, but active | 487 |
| | 4,092 |
| Number who have paid state dues but not AMA dues as of March 31, 1965 | 94 |

* Includes 302 senior and 3 honorary members

### Headquarters Office

On motion of Drs. Larson and Neumann the executive secretary was authorized to renew the Blue Cross-Blue Shield contract for the association employees.

### Building Matters

An additional bid for the ceiling and lighting of the basement was presented by the Dodd Electric Service, who quoted a total of $2,382.00. On motion of Drs. Larson and Black, the chairman of the Building Committee was authorized to accept this bid.

### Treasurer's Office

The treasurer gave a report on the statement of condition on investments as of February 28 and on cash balances in funds as of March 31. His report was approved on motion of Drs. Neumann and Rifner.

### Annual Convention, October 12-14, 1965, Indianapolis

A letter from the Chicago Gaslight Club concerning costs for a gaslight party during the annual convention was reviewed. On motion of Drs. Rifner and Larson, the proposal was accepted.

*Honorariums.* The action of the Council regarding payment of honorariums was reviewed for interpretive purposes and upon motion of Drs. Neumann and Olvey, the Executive Committee set a limit of $200.00 for honorarium to any one speaker.

### Legislation

*National*: A brief report was made of the Medicare proposal currently before Congress.

*Local*: The president spoke of a meeting with the Farm Bureau, the Chambers of Commerce and the Manufacturers Association to discuss the problems Indiana faces due to the recent action of the state legislature in reapportioning this state. On motion of Drs. Black and Olvey, the association will support these efforts and will inform its members on this matter and urge their support.

### Organization Matters

A letter from the president of the Woman's Auxiliary thanking the association for its $1,000.00 contribution was reviewed for the information of the committee.

A letter from the St. Joseph County Medical Society concerning some membership problems that that society was having and the executive secretary's unofficial reply were reviewed, and upon motion of Drs. Rifner and Neumann, the secretary was instructed to notify the St. Joseph County Medical Society that his unofficial reply should be considered an official reply.

The letter from the Commission on Voluntary Health Agencies recommending the naming of Dr. James R. Mathews of Evansville to the Core Planning Committee on Cardiovascular Diseases was approved.

Dr. Rifner stated there was some dissatisfaction concerning a letter being sent by the Commission on Voluntary Health Agencies to agencies which they had approved, specifically pointing out the commission was authorizing the use by these agencies on their letterhead of the phrase "Approved by the Indiana State Medical Association for the year 1965." The commission is to be requested to discontinue this practice and to reword its statement. It was so moved by Dr. Rifner and adopted by consent.

A letter from the Commission on Governmental Medical Services requesting the authority to make a study of welfare fees in existence throughout the state of Indiana was approved on motion of Drs. Olvey and Larson.

A resolution from the Daviess-Martin County Medical Society was read for the information of the committee.

A notice that the term of Dr. Mericle as a member of the Hospital Licensing Council will expire in May, 1965, was read, and upon motion of Drs. Olvey and Larson, the reappointment of Dr. Mericle was to be recommended by the association.

A letter from Lewis F. Nicolini, director of the Indiana Employment Security Division, was read and by consent the secretary was instructed to notify Mr. Nicolini that the fee of $15.00 for the type of examination which is required, in many instances would not even pay the laboratory charges for the tests required in said examination.

A resolution from the New Mexico Medical Society on the Joint Commission on Accreditation of Hospitals was read for the information of the committee.

A letter from J. Neill Garber, M.D., was read for the information of the committee.

A report made by Dr. Jene Bennett on his attendance at the meeting of the Michigan Association of Professions was noted, and inasmuch as this would be reported to the Council, no action was taken.

Report of Dr. Glen Ward Lee concerning his attendance at the 11th Annual Conference of State Mental Health Representatives in Chicago was reviewed for the information of the committee.

A letter from the Commission on Medical Education and Licensure was read. Upon motion of Drs. Neumann and Larson, the letter is to be referred to the Council and a recommendation is to be made that in the future the association not approve any survey until the association has all the facts.

A letter from a firm of attorneys concerning an Indiana physician who has surrendered his license to practice medicine was read for the information of the committee.

A letter from the Student American Medical Association acknowledging renewal membership of the association in this organization was reviewed for the information of the committee.

Letters concerning the candidacy of Dr. Bibler for AMA trustee were reviewed.

## New Business

Dr. Black discussed the appearance of Dr. James Z. Appel during the I.U. alumni program and suggested that the association help defray the expenses of a reception for Dr. Appel. This was approved on motion of Drs. Larson and Olvey.

Plans were discussed for the New York meeting in June and by consent it was agreed that the headquarters hospitality room in the Americana Hotel would operate from 12 to 2 p.m. and from 4:30 to 7:00 p.m. during the days of the meeting.

## The Journal

Letter from the State Medical Journal Advertising Bureau concerning split runs was reviewed and quotations given, and by consent the secretary was instructed to inform the State Medical Journal Advertising Bureau that the association would not participate in this program at the present time.

A proposal from the State Journal Advertising Bureau concerning reduction in contract rates for 36 insertions was approved on motion of Drs. Larson and Neumann.

## Future Meetings

U. S. Chamber of Commerce, Washington, April 25-28, 1965. Renewal of membership in the United States Chamber of Commerce in the amount of $50.00 was approved by consent.

Tri-State Hospital Assembly, Chicago, April 26-28, 1965. No representative will be sent to this meeting.

AMA 10th National Conference on Physicians and Schools, Chicago, September 23-25, 1965. By consent it was agreed that a representative from the appropriate commission be authorized to attend this meeting.

State Journal Advertising Bureau, Chicago, October 23-24, 1965. The business manager and editorial assistant were authorized to attend this meeting, on motion of Drs. Larson and Olvey.

Indiana Association of Medical Assistants. The secretary was instructed to secure the date of the annual meeting of this organization so that someone may represent the association.

There being no further business, the committee adjourned to meet again on Saturday, May 15, 1965, at 3.00 p.m. in the headquarters office. ◄

# Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1965 annual meeting of the Indiana State Medical Association, Oct. 12-14 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

---

## Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

_____

# COMMERCIAL ANNOUNCEMENTS

OUTSTANDING opportunity for physician specializing in internal medicine to be affiliated with well established group in large metropolitan center. Five internists practicing in group. Compensation excellent and no investment necessary. Reply to Box 310, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

GENERAL Practice office for sale; five rooms, air conditianed, records included, excellent location near three hospitals and close to excellent residential area; large parking lot. Leaving in July to specialize. Contact: Michael Truman, M.D., Hamilton, Ohio — 89-54541.

FULLY equipped office and home available for physician in Morocco, Indiana, a stable rural community of 1,200 people and serving an area of more than 3,500. For further details contact the Administrator of the George Ade Memorial Hospital in Brook, Indiana.

DOCTORS office available for immediate possession. Central heating and air conditioning. Located vicinity 10th and Arlington, Indianapolis. Call FL9-5455, Justus Contracting Co.

WANTED: Board eligible certified internist to associate with general surgeon, ophthalmologist and urologist, giving advantage of both solo and group practice. Practice located on Lake Michigan in Wisconsin with population af approx. 50,000 with drawing area of 90,000. Address enquiries to Box No. 316, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

FOR RENT: Six room suite office in professional bldg., Greenwood, Ind. Clinical and x-ray labs and prescription pharmacy in building. Ample paved parking. Terms: very good professional and character references. Rent 15% of monthly gross until figure reaches $290.00 per mth. No retroactive payments. Contact Kenneth I. Sheek, M.D., 360 S. Madison, Greenwood, TU1-3900 for appointment.

WANTED: one or twa E.E.N.T. associates to take over best practice in Northern Indiana due to retirement. Eight fully equipped, air conditioned rooms, full surgical equipment. High net income . . . small down payment; will remain to introduce. Write Box No. 317, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

PROFESSIONAL office suite for physician or dentist available in N.E. Indianapolis (outside city limits but 30 minutes from Circle.) Air conditioned. For full details call VA3-4413 or VA3-4528.

GENERAL practice for sale, can include house and office. Or will sell practice and lease office. Contact L. H. Wiatt, M.D., 108 N. Washington St., Knightstown, Ind., or call Knightstown 5-4405 collect, after 7.00 p.m.

RESIDENCIES—Internships, fully approved in 372-bed hospital with excellent teaching program; vacancies for 12-month rotating internships. Vacancies for 2-year pathology, 2-year general practice, 3-year ob-gyn residencies. Salaries: interns $350 per month, residents $400-$500 per month. Blue Cross family insurance, meals, partial maintenance. Write Director of Medical Education, St. Mary's Hospital, 3700 Washington Ave., Evansville, Indiana 47715.

FOR SALE: Haynes manual hydraulic rectal examining table; two matched walnut Allison "Monarch" treatment and instrument cabinets. Call Richard B. Moore, M.D. CL5-1606, St. Paul, Minn.

FOR SALE: G. E. Cardiograph, recently reconditioned, excellent shape, good buy for new M.D. $395.00 cash. Call VE1-3900, Mooresville, Ind., 9 a.m. ta 5:30 p.m.

MEDICAL office available, air conditioned, six room cottage in center af town. Leased parking-12 cars. Fully equipped if desired. Contact C. E. Thorne, M.D., 200 N. 12th Street, New Castle, Ind.

## NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

First four lines: $3.00
each additional line: 50¢

ISMA members may repeat an ad in the following issue without charge. This is limited to one free ad per year.

Advertiser will be billed at the end of the designated period of insertion(s), or at the end of each three-month period, whichever is shorter.

DEADLINE: Fifth day of month PRECEDING month of issue. (The Journal is in press approximately one month.)

## SPECIAL NOTICE

June issues and the 1964-65 Roster may be obtained from the JOURNAL, 3935 N. Meridian, Indianapolis.

Roster: $3.00 each.

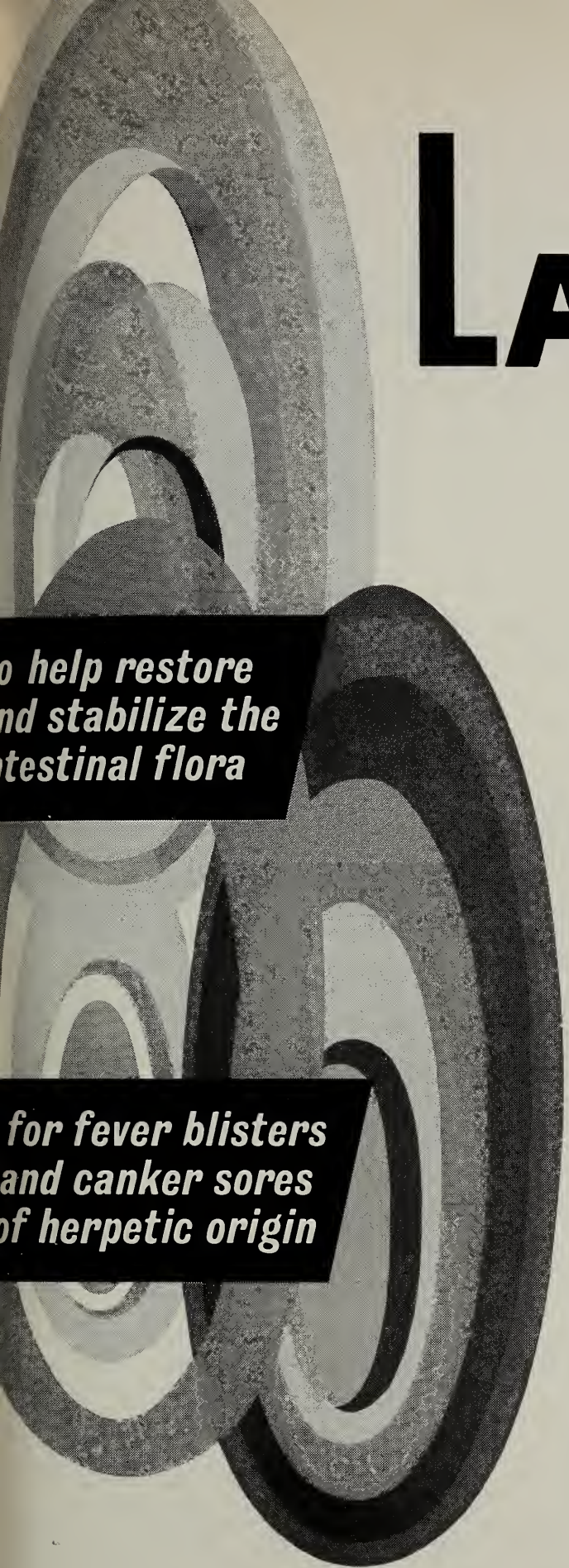
Yearbook: $5.00 each.

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No untoward side effects have been reported in 12 years of clinical use.

*Literature on indications and dosage available on request.*

*(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.*

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JUNE 1965

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication
3935 N. Meridian, Indianapolis, Indiana

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EDITORIAL AND ADVERTISING INFORMATION

All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

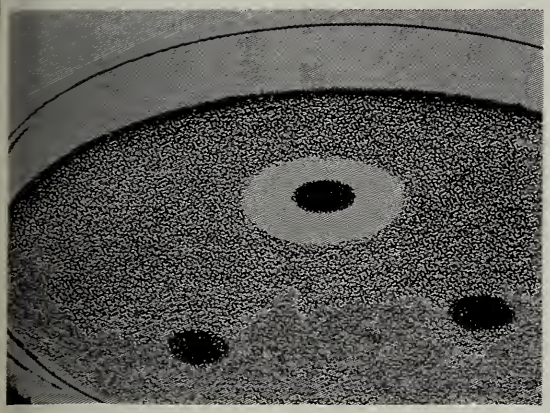
Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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Before they can develop into pyelonephritis, pyonephrosis or some other potentially life-threatening urinary condition. With NegGram, a specific urinary antibacterial. Clinical reports and extensive patient use show that in adults two 500 mg. NegGram Caplets® orally four times a day will control most urinary infections. Quickly...effectively...with minimal side effects. **Gram-negative urinary infection—cystitis, pyelitis, pyelonephritis, prostatitis, urethritis? Start first with NegGram ..."a good 'starting' drug."**[1] NegGram "...treatment may be first choice in potentially curable gram negative bacterial urinary infections."[2]

**Indications:** Urinary tract infections caused by gram-negative and some gram-positive organisms.

**Side effects:** Mainly mild, transient gastrointestinal disturbances; in occasional instances, drowsiness, fatigue, pruritus, rash, urticaria, mild eosinophilia, reversible subjective visual disturbances (overbrightness of lights, change in visual color perception, difficulty in focusing, decrease in visual acuity and double vision), and reversible photosensitivity reactions. Marked overdosage, coupled with certain predisposing factors, has produced brief convulsions in a few patients.

**Precautions:** As with all new drugs, blood and liver function tests are advisable during prolonged treatment. **Pending further experience, like most chemotherapeutic agents, this drug should not be given in the first trimester of pregnancy. It must be used cautiously in patients with liver disease or severe impairment of kidney function.** Because photosensitivity reactions have occurred in a small number of cases, patients should be cautioned to avoid unnecessary exposure to direct sunlight while receiving NegGram, and if a reaction occurs, therapy should be discontinued. The dosage recommended for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Bacterial resistance may develop.

When testing the urine for glucose in patients receiving NegGram, Clinistix® Reagent Strips or Tes-Tape® should be used since other reagents give a false-positive reaction.

**Dosage: Adults: Four Gm. daily by mouth (2 Caplets® of 500 mg. four times daily) for one to two weeks. Thereafter, if prolonged treatment is indicated, the dosage may be reduced to two Gm. daily. Children may be given approximately *25 mg. per pound* of body weight per day, administered in divided doses. The dosage recommended above for adults and children should not arbitrarily be doubled unless under the careful supervision of a physician. Until further experience is gained, infants under 1 month should not be treated with the drug.**

**How supplied:** Buff-colored, scored Caplets® of **500 mg. for adults,** conveniently available in bottles of 56 (sufficient for one full week of therapy) and in bottles of 1,000. **250 mg. for children,** available in bottles of 56 and 1,000.

**References:** (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

# THE INDIANA STATE MEDICAL ASSOCIATION

3935 N. Meridian, Indianapolis 46208—Telephone WAlnut 5-7545

## ANNUAL CONVENTION—OCTOBER 12 - 14, 1965—INDIANAPOLIS

### OFFICERS FOR 1964-65

President—Joe M. Black, M.D., 502 W. Second St., Seymour.

President-Elect—Kenneth O. Neumann, M.D., 618 Life Bldg., Lafayette.

Treasurer—Ottis N. Olvey, M.D., 3769 Park Ave., Indianapolis 5.

Assistant Treasurer—Lester H. Hoyt, M.D., Methodist Hospital, Indianapolis.

Executive Secretary—Mr. James A. Waggener, 3935 N. Meridian, Indianapolis 8.

Administrative Assistant—Mr. Kenneth W. Bush, 3935 N. Meridian, Indianapolis 8.

Assistant to the Executive Secretary—Miss Lucille Kribs, 3935 N. Meridian, Indianapolis 8.

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Field Secretary—Mr. Howard Grindstaff, 3935 N. Meridian, Indianapolis 8.

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Assistant Editor—Jackie Freers Stahl, 3935 N. Meridian, Indianapolis 8.

### COUNCILORS

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| 2—E. T. Edwards, Vincennes | Oct. 1966 |
| 3—Donald M. Kerr, Bedford | Oct. 1967 |
| 4—Robert M. Reid, Columbus | Oct. 1968 |
| 5—V. Earle Wiseman, Greencastle | Oct. 1966 |
| 6—William R. Tindall, Shelbyville | Oct. 1967 |
| 7—Albert M. Donato, Indianapolis | Oct. 1968 |
| 8—Donald R. Taylor, Muncie | Oct. 1966 |
| 9—Peter R. Petrich, Attica | Oct. 1967 |
| 10—Lowell H. Steen, Whiting | Oct. 1968 |
| 11—E. S. Rifner, Van Buren (chairman) | Oct. 1966 |
| 12—Milton F. Popp, Fort Wayne | Oct. 1967 |
| 13—Jene R. Bennett, South Bend | Oct. 1965 |

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| District | Term Expires |
|---|---|
| 1—Gilbert M. Wilhelmus, Evansville | 1967 |
| 2—Philip T. Holland, Bloomington | 1965 |
| 3—Elmer L. Wallace, New Albany | 1968 |
| 4—Jack E. Shields, Brownstown | 1967 |
| 5—A. W. Cavins, Terre Haute | 1966 |
| 6—Frank Green, Rushville | 1966 |
| 7—Charles A. Jones, Franklin | Spring, 1966 |
| 8—Paul Sparks, Winchester | 1966 |
| 9—Albert E. Stouder, Kempton | Fall, 1965 |
| 10—Lee Trachtenberg, Hammond | Fall, 1966 |
| 11—Lowell Hillis, Logansport | 1965 |
| 12—William Clark, Fort Wayne | Spring, 1968 |
| 13—Robert L. Rouen, Elkhart | 1967 |

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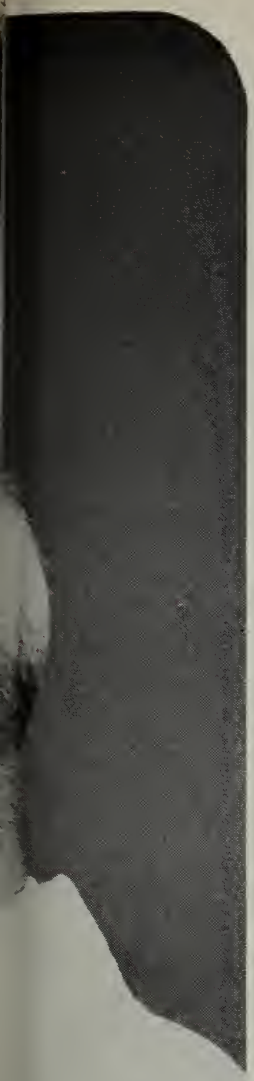
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**Terms expire December 31, 1966:**

| Delegates | Alternates |
|---|---|
| Harold C. Ochsner, Indianapolis | James H. Gosman, Indianapolis |
| E. S. Jones, Hammond | Robert M. Brown, Marion |
| Francis L. Land, Fort Wayne | Frank H. Green, Rushville |

**Terms expire December 31, 1965:**

| Delegates | Alternates |
|---|---|
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| 2. | Joe E. Dukes, Dugger | J. S. Brown, Carlisle | |
| 3. | Marion Hagan, French Lick | Arthur L. Wagner, Jasper | |
| 4. | Merritt O. Alcorn, Madison | Francis W. Hare, Jr., Madison | Madison, 1966 |
| 5. | Robert M. Fell, Rosedale | J. W. Somerville, Clinton | |
| 6. | William E. Murray, New Castle | Paul M. Inlow, Shelbyville | |
| 7. | William C. Stafford, Plainfield | James H. Gosman, Indianapolis | |
| 8. | Warren L. Bergwall, Muncie | David J. Dietz, Muncie | |
| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | |
| 10. | Michael Shellhouse, Gary | Edward J. Dierolf, Gary | |
| 11. | Fred C. Poehler, La Fountaine | Max M. Earl, Kokomo | Peru, Sept. 15, 1965 |
| 12. | Warren L. Niccum, Columbia City | Kenneth F. Isenogle, Fort Wayne | May 18, 1966 |
| 13. | Guy B. Ingwell, Knox | Cecil R. Burket, Bremen | |




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The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Psoriatic arthritis responds in the same way as rheumatoid arthritis but the skin lesions are usually not affected either favorably or adversely by treatment.

**Precautions**
Before prescribing, the physician should obtain a complete history and perform a complete physical and laboratory examination, including a blood count.

The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools.

If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

**Side effects**
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug.

**Contraindications**
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when other potent chemotherapeutic agents are given concurrently because of the increased possibility of toxic reactions; when the patient cannot be seen regularly; when the patient is senile.

*Note:* The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

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*Interpreted by*
*ROBERT HOLLOWELL, LL.B., legal counsel*
*Indianapolis*

Under date of December 29, 1964, a Deputy Attorney General, Howard R. Johnson, wrote a letter to Mr. John H. Kesling, President of the Indiana Board of Pharmacy, concerning the supplying or delivery of drugs by physicians. It is my information that, based upon this letter that Mr. S. M. Wynkoop, an inspector for the State Pharmacy Board, made certain investigations and filed certain affidavits against physicians. Some of these are for the operation of a pharmacy without a permit and some for violation of the Dangerous Drug Act of 1961.

1. This letter of Mr. Johnson's is not an official opinion of the Attorney General. I am advised that it was not even processed as an unofficial opinion. It is merely a letter expressing the personal views of Mr. Johnson and has no official standing as an opinion of the Attorney General or precedent of the Attorney General's office.

I am in disagreement with the views expressed by Mr. Johnson in this letter. In said letter he states that the real purpose of the "Dangerous Drug Act" was to prevent the dispensing thereof by employees of physician and surgeons. This was not the purpose of the Act. The occasion of the Act was that the Prosecuting Attorney of Marion County and the Food and Drug Division of the Board of Health were having problems in being able to enforce an Act of 1955 which related to barbiturates and amphetamine and, more specifically, in their being obtained by truck drivers from filling stations and elsewhere and similar situations and to "afford the public the therapeutic benefits of dangerous drugs under medical supervision."

In said letter, Mr. Johnson makes the following statement:

> "Various questions which we have answered are that the doctor may prepackage the dosages, but must, nevertheless, deliver the medication personally to the patient; that the label need not be in the doctor's handwriting, but the same can be typed by an employee in his office; that the doctor cannot leave the medication, even though he prepares it with someone in his office, for the patient to pick up in the doctor's absence, but the same must be delivered personally."

With this statement, I am in total disagreement. In my opinion it is entirely lawful for a duly licensed physician to direct his nurse, orally or in writing, to deliver a particular prescription drug to his patient; or to, in person or by his nurse or other competent office employee, repackage the drugs, properly label the same, and deliver it to the patient or leave with an employee in his office for the patient to pick up in the doctor's absence. I do not believe that this is prohibited by said "Dangerous Drug Act." Nor do I believe the physician is required to personally hand the drug to the patient.

It is, and for many years has been, common and accepted procedure and practice for a physician to have as employees persons who are his assistants in the conduct of his office practice and procedure. These may consist of one or more nurses, and he may have various technicians, such as x-ray technician, laboratory technician, and others with special training and skill in the duties and procedures assigned to them. These may or may not be registered nurses. Many such technicians have more training and skill in their respective fields than a registered nurse might have. This may include a person with as much or more qualifications for repackaging and labeling a drug as a registered nurse might have. I see no difference in the legal right of the

physician to employ a technician as an assistant to take x-rays or give an electrocardiogram, or make a urinalysis or blood test, and his legal right to employ as his assistant a person qualified to repackage a drug under the direction of such physician.

Whether his nurse or office assistant is competent to perform this act involves the duty of the physician to select competent assistants and employees. A failure to exercise reasonable care in that regard may expose the physician to malpractice liability, but that is a different question from his legal right to employ nurses and technical and other office help to assist him. The physician alone may diagnose and determine the need and dosage of a particular drug. When he has done that, he may turn over to his nurse, technician, or other competent office assistant the mechanics of the process of getting that drug, properly labeled, from his drug supply to the patient.

There is one possible exception which relates only to professional samples of prescription drugs in their original containers. This arises under Section 3(a) of the Dangerous Drug Act and which specifically requires the physician to give the patient oral directions for use "at the time of such delivery." It may be possible to construe this requirement of oral direction for use to include a personal contact between the physician and his patient at the time of the delivery of such professional sample. Upon this I express no final opinion.

2. Section 63-1114, Burns' Indiana Statutes, Ann., 1961 Replacement, contains this exception to the Pharmacy Licensing Law:

> ". . . That nothing in this act shall apply to, nor in any manner interfere with, the business of a regularly licensed physician in compounding for and supplying his patients with such medicines as may seem to him proper in his professional capacity as a physician: . . . ."

Under this exception, it is my opinion that the Pharmacy Licensing Laws do not apply to, or in any manner interfere with, the practice of the legally licensed physician in compounding for and supplying his patients with prescription or other drugs.

I point out that narcotics, as defined in the Narcotic Laws, and drugs, covered by the so-called "Dangerous Drug Act," are not exactly comparable. Narcotics receive special treatment. Before a physician may possess or dispense a narcotic drug, he must register and pay the tax provided by Federal Law and keep the special records required by Federal Law. On the other hand, "Dangerous Drugs" is just a term used in the 1961 Act to include all drugs which under Federal Law are required to bear a label, "Caution: Federal Law prohibits dispensing without a prescription." In other words, it applies to all prescription drugs, many of which could not be considered as particularly dangerous or at all comparable to narcotics, nor would they be considered habit forming or likely to result in an addiction. Yet, the 1935 Narcotic Law contains this provision:

> *"10-3525. Professional use of narcotic drugs.* — (1) A physician or a dentist, in good faith and in the course of his professional practice only, may prescribe, administer, and dispense narcotic drugs, or he may cause the same to be administered by a nurse or interne under his direction and supervision."

With the law expressly authorizing the administering of a narcotic by a nurse, it certainly could not be contended that less hazardous prescription drugs had to be personally administered by the physician.

The 1935 Narcotic Law was adopted as a uniform law. In Indiana an intern ordinarily holds an unlimited license to practice medicine, and is a physician. The Uniform Narcotic Law is a special law, and its application is limited to "Narcotic Drugs" as defined therein. It has no application to the sale or dispensing of any drug not defined therein as a narcotic drug.

3. A physician holds an unlimited license to practice medicine, surgery, and obstetrics. This authorizes and empowers him to do anything which constitutes the practice of medicine. This is an affirmative right which is independent of the Pharmacy Law and any exceptions therein. Sec. 63-1311, Burns' Ind. Stat., Ann., 1961 Repl., defines the practice of medicine as follows:

> *" 'Practice of medicine' defined — In-*

*junction to restrain unlicensed practicing.* — To open an office for such purpose or to announce to the public in any way a readiness to practice medicine in any county of the state, or to prescribe for, or to give surgical assistance to, or to heal, cure or relieve, or to attempt to heal, cure or relieve those suffering from injury or deformity, or disease of mind or body, or to advertise, or to announce to the public in any manner a readiness or ability to heal, cure or relieve those who may be suffering from injury or deformity, or disease of mind or body, shall be to engage in the practice of medicine within the meaning of this act. (§§63-1311-63-1314): . . . ."

In *Fowler, Adm v. Norways Sanatorium*, 112 Ind. App. 347 at p. 357, the Court said:

"In the case of *Underwood v. Scott* (1890), 43 Kan. 714, 717, 23 P. 942, 943, the court defines the practice of medicine as follows:

" 'The practice of medicine may be said to consist in three things: First, in judging the nature, character and symptoms of the disease; second, in determining the proper remedy for the disease; third, in giving or prescribing the application of the remedy to the disease.' "

Definitions of the practice of medicine include "treatment" or "to treat" illness, such as the following: "To operate on, profess to heal or prescribe for, or otherwise treat any physical or mental ailment of another."

Different statutes relating to the practice of medicine and to drugs have used different terminology and words, such as "supply," "deliver," "furnish," "give," "administer," "dispense," and "sale." In my opinion these words as used in reference to the supplying, etc. of medicine or drugs by a physician to his patient usually have the same meaning. For example, in the definition section of the "Dangerous Drug Act" "sale" is defined as follows in Sec. 35-3332, H. (4), (5), Burns' Ind. Stat., Ann., 1949 Repl., pamphlet pt.:

*"Definitions. — H.*

"(4) dispensing, giving, delivery or any other supplying, and (5) applying, administering, or any other using."

"Sale" in the Food and Drug Law is defined in Sec. 35-3103, as follows:

*"Definitions.* — (c) (4) dispensing, giving, delivering, serving, or any other supplying; and (5) applying, administering, or any other using."

In my opinion, any physician holding an unlimited license to practice medicine may, as a part of his treatment of his patient, lawfully furnish, supply, give, administer, dispense, or sell any drug to his patient, and to utilize his assistant and office employees in the packaging, labeling, and physical delivery of the drug to his patient, under the direction and supervision of the physician.

However, as to narcotic drugs, compliance must also be had with both State and Federal laws relating to narcotics as defined in said laws.

So far, I have confined this memorandum to the ordinary or normal "office practice" of a physician or a small number of physicians occupying the same offices where the nurse, technician, or employee are employed by and responsible to the physician supplying or dispensing the drug to his patient, and acting under his supervision.

4. However, there is one type of practice which has recently developed, and sometimes referred to as "group practice" or "clinic practice," where a substantial number of doctors are associated in the practice in the same suite or building, and where there is maintained a drug room which contains a supply of drugs comparable to that of at least a small pharmacy, and which drug room is in charge of a person who is not a direct employee of any one physician, but is a common employee of a substantial number of physicians. In some instances, some of the physicians may themselves be employees of other physicians and have no employment relationship with the person in charge of the drug room. Both the Medical Practice Act and the Pharmacy Licensing Laws came into being and were largely written long prior to the development of this type of group or clinic practice, and, consequently, there is no specific language in either law which was originally written with this type of group or clinic practice

Continued

# New broad-spectrum penicillin but without broad-spectrum toxicity[1-10]

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*Contraindications:* (1) Hypersensitivity to penicillin. (2) Infections by penicillinase-producing staphylococci and other penicillinase-producing organisms.

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*Precautions:* As with other antibiotics, precautions should be taken against gastrointestinal superinfection. To date, safety for use in pregnancy has not been established.

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*References:* 1. Editorial. Brit. M. J. *ii*:223 (July 22) 1961. 2. Rolinson, G. N., and Stevens, S.: Brit. M. J. *ii*:191 (July 22) 1961. 3. Stewart, G. T., *et al.:* Brit. M. J. *ii*:200 (July 22) 1961. 4. Brown, D. M., and Acred, P.: Brit. M. J. *ii*:197 (July 22) 1961. 5. Batchelor, F. R., *et al.:* Nature *183*:257, 1959. 6. Knudsen, E. T., *et al.:* Brit. M. J. *ii*:198 (July 22) 1961. 7. Doyle, F. P., *et al.:* Nature *191*:1091 (Sept. 9) 1961. 8. Acred, P., *et al.:* Brit. J. Pharmacol. *18*:356, 1962. 9. Harrison, P. M., and Stewart, G. T.: Brit. J. Pharmacol. *17*:420, 1961. 10. Editorial. Lancet *ii*:723 (Oct. 5) 1963.

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## MEDICOLEGAL MEMOS

Continued

specifically in mind.

This type of practice may require court decision or further legislation to furnish an answer. Until there is either additional clarifying court decision or additional legislation directly applicable, I can only give my best judgment. It seems to me that the reasonable test is whether the employee delivering the drug to the patient is directly responsible to the physician supplying the drug, and acting under his supervision, or whether a third person is involved in the delivery who is not an employee or directly responsible to said physician, and who is not acting under the supervision of said physician.

In this connection I also point out that there is no definition of the practice of pharmacy in the Pharmacy Laws. Neither is there any provision in said laws making it unlawful to practice pharmacy without having a license as a registered pharmacist.

In this memoranda, I am excluding any consideration of questions as they relate or apply to the drug room or pharmacy of a licensed hospital. I am also excluding consideration of questions of ethics and policy and confining this memoranda to my opinion of a physician's legal rights in supplying and dispensing drugs to his patients. ◀




**The sad part of it is that your ears took hi-fi as long as they could, sir, and then they just gave up!**

April 5, 1965

Circular ST-20
(Revised)

TO: PHYSICIANS AND SURGEONS

FROM: SALES TAX DIVISION

This circular replaces Circular ST-20 dated May 27, 1964

A. *Payment of Sales Tax by Physicians and Surgeons*

1. **PROFESSIONAL SERVICES:**

Receipts derived by physicians and surgeons for professional services rendered are not taxable under the gross retail tax.

2. **PURCHASES BY PHYSICIANS AND SURGEONS:**

All purchases by physicians and surgeons are subject to the sales tax with the exception of drugs of the type which may be sold only upon a prescription, insulin, oxygen, blood or blood plasma, when such items are to be directly consumed in professional use.

3. **SALES BY PHYSICIANS AND SURGEONS:**

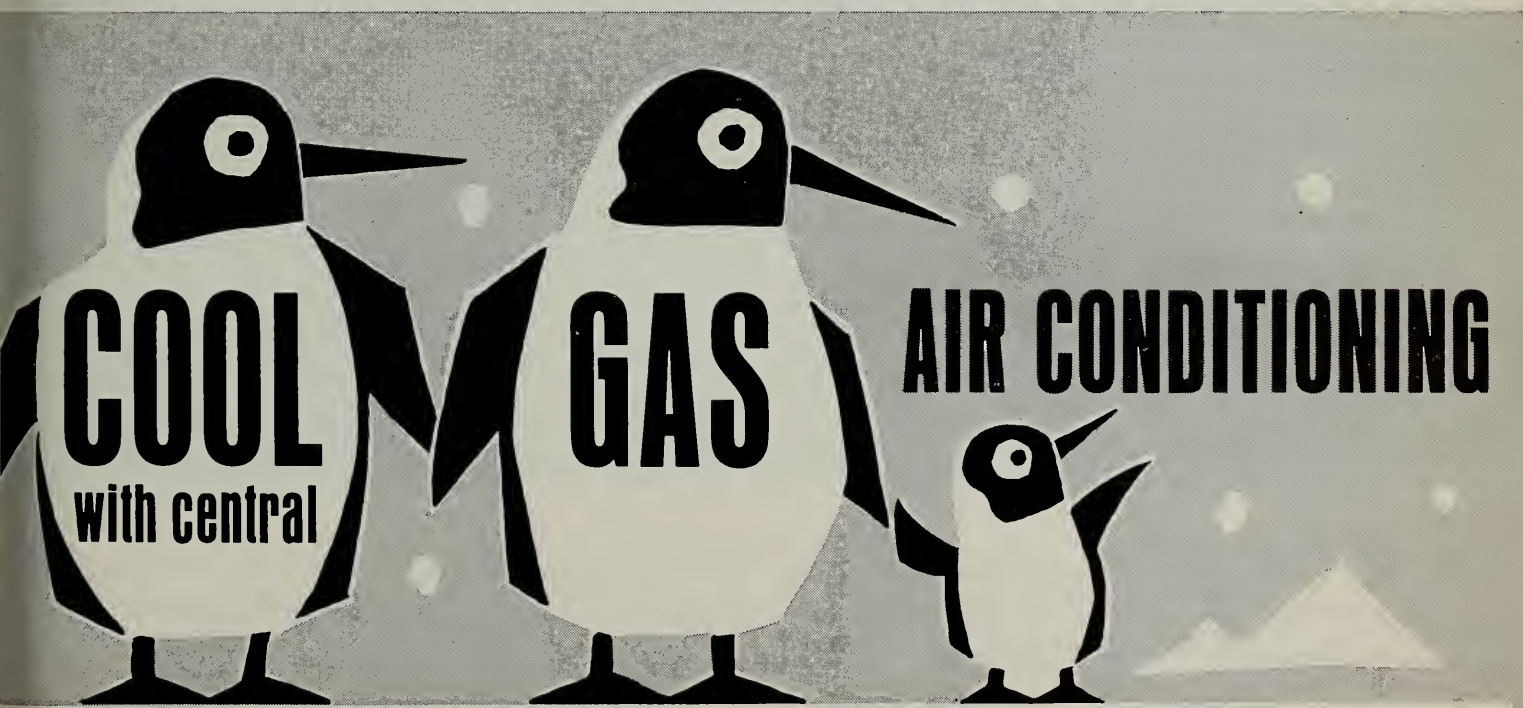
Physicians and surgeons are no longer retail merchants under the gross retail tax and therefore will not collect sales tax upon sales made by them of drugs in their professional practice.

B. *Purchases by Physicians for Tax Exempt Purposes*

If a physician makes purchases of exempt items he should issue an exemption certificate.

THE FOREGOING INTERPRETATIONS WILL BE ADHERED TO AND APPLIED UNTIL CHANGED OR RESCINDED BY THE DEPARTMENT OF REVENUE, OR UNTIL REPLACED BY OFFICIAL REGULATION, OR NULLIFIED BY COURT DECISION, OR OFFICIAL OPINION OF THE ATTORNEY GENERAL.

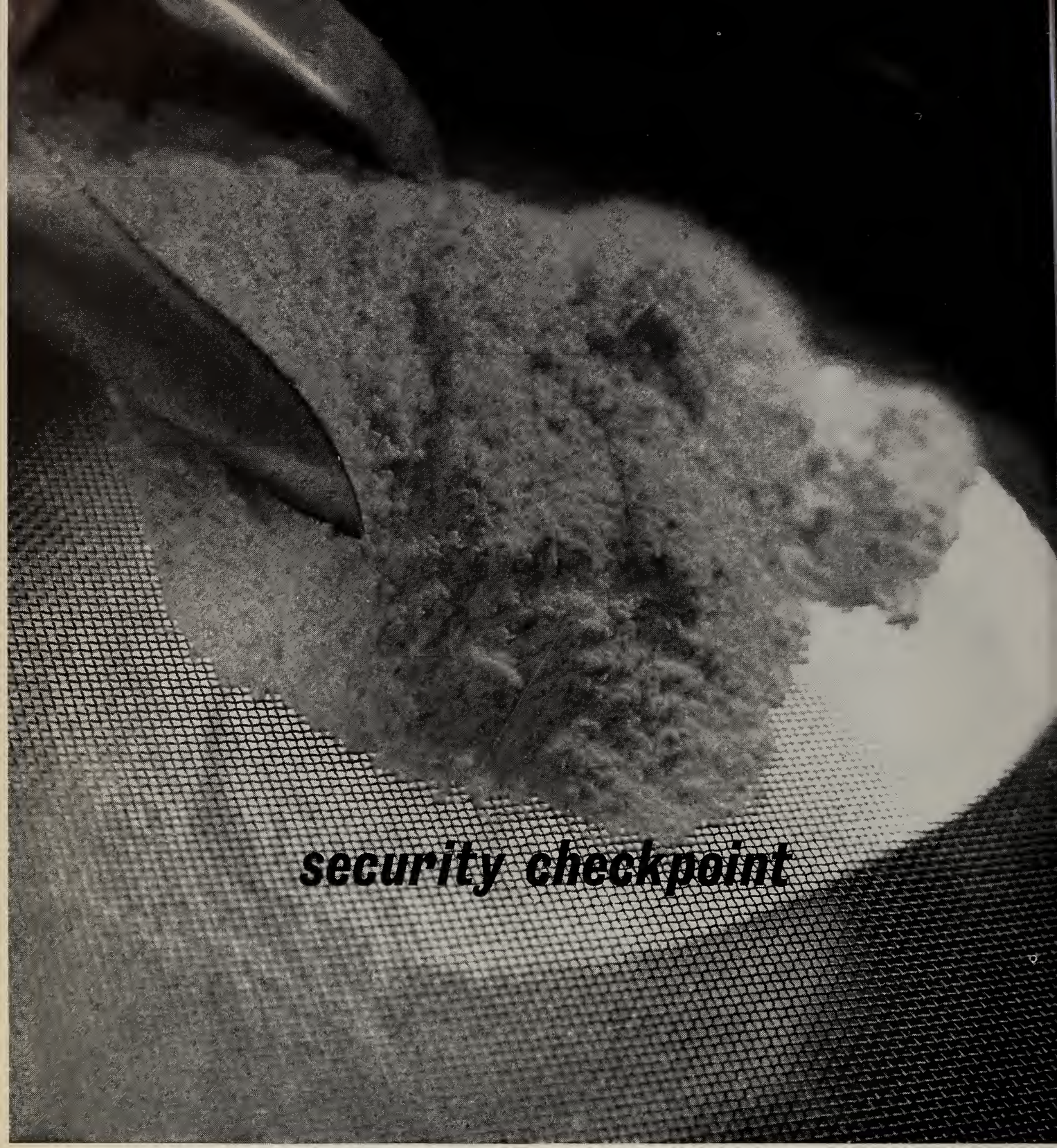
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 58 — June 1965 — Number 6

# Skin Testing for Tetanus Antitoxin

IRVIN CAPLIN, M.D.
*Indianapolis*

MANY TIMELY articles continue to appear on tetanus and point to the grave necessity of immunizing everyone with tetanus toxoid. However, until the day is reached when human tetanus immune globulin becomes plentiful, we are faced with the ordeal of employing foreign serum with all its potential and real danger. It is obvious that improper testing is done.[1-3] This resume is intended to bridge the gap in an apparent lack of instruction in medical education concerning proper testing for foreign serum sensitivity.

In 1960, Buff[1] reported fatal anaphylactic shock from a skin test to tetanus antitoxin; 0.1 cc of a 1-10 dilution of antitoxin was injected intradermally. Death occurred one hour later. In 1961, in a letter to the editor of the *JAMA*, Luton[2] cautioned that serum for testing should be diluted to 1-100 and only .01 cc be used intradermally. Buff, in his answer, stated that drug manufacturers recommended intradermal testing with 0.1 cc of a 1-10 dilution of antitoxin. In view of the fatality in his case, he felt certain that less should be used for testing and drug manufacturers should change their brochures.

I have reviewed several brochures and will quote directly from the brochure of the company which supplies most of the antitoxin used in our area. "A skin test for sensitivity may be done by injecting .05-0.1 cc of a 1-10 dilution of serum intradermally." A copy of this paper is being sent to the drug company with the recommendation that they review and change their brochure.

Although there is only one reported death from skin testing with tetanus antitoxin, I wonder if there have not been many more unreported deaths. From personal knowledge, I know of three patients who fortunately escaped death following skin testing with tetanus antitoxin. All had shock, asthma, urticaria, vomiting and itching of the scalp. One patient developed this reaction from a scratch test of full strength horse serum tetanus antitoxin. I feel, that in his case, intradermal testing may have been fatal. One patient developed this reaction from 0.lcc of a 1-10 dilution of horse serum tetanus antitoxin injected intradermally. The third patient received 0.1 cc of full strength tetanus antitoxin intradermally. Her shock was profound. In addition to epinephrine and intravenous fluids, she required continuous Levophed for 24 hours.

One other patient is worthy of mention. Following an injury, this patient was tested with 0.1 cc of 1-10 dilution of horse serum tetanus antitoxin. Because of a false positive reaction, antitoxin was withheld. Within one week, he developed tetanus. Retesting with .01 cc of a 1-100 and 1-10 dilution of plain horse serum was negative. He was given antitoxin without reaction and recovered. With proper testing, he may have been spared the development of clinical tetanus.

Proper skin testing has a two-fold purpose:

1. False positive reactions are avoided and antitoxin need not be unnecessarily withheld.
2. The possibility of death from skin testing or administering prophylactic

or therapeutic antitoxin to an atopically sensitive patient is avoided.

### Technic

The technic used to determine serum sensitivity at the Methodist Hospital Postgraduate Medical Center is as follows:

1. Normal horse serum is used for testing and not tetanus antitoxin. Criep[4] stressed this in 1945. He again described Foshay's E-E reaction. This is the edematous-erythematous reaction which is nonspecific and caused by antitoxin. Many false positive reactions are due to this E-E reaction.

2. Scratch testing is done first. In view of our experience of a near fatality from scratch testing with full strength horse serum, we are now scratch testing with a 1-100 dilution of plain horse serum.

3. Intradermal testing is done only when the scratch test is negative. Although a 1-100 dilution is felt to be safe in all but the exquisitely sensitive, we start intradermal testing with a 1-1000 dilution of plain horse serum. How else can we be certain that the patient before us is not one of the exquisitely sensitive?

The amount injected intradermally is .01-.02 cc. It is not 0.1 cc. The 0.1 cc volume is employed for the delayed reactions in bacterial sensitivity. The prime example is the tuberculin test. With horse serum we are testing for reagin (skin sensitizing antibody). The reaction is not delayed but immediate, occurring within 10-20 minutes. Whether the antigen is ragweed, dust, foods, or foreign serum, just enough antigen to produce a small bleb is injected intradermally; .01 cc is preferable and never more than .02 cc.

If the skin test to 1-1000 is negative in 15-20 minutes, testing is repeated with a 1-100, and finally with a 1-10 dilution of plain horse serum.

If all tests are negative, it is felt that an immediate constitutional reaction is most unlikely although the development of serum sickness cannot be predicted. If one is dealing with an atopic individual and there is still concern in spite of negative skin tests, 0.1 cc of the undiluted antitoxin is given subcutaneously. If there is no reaction in 30 minutes, the entire dose can be given.

4. When skin tests are positive, bovine serum antitoxin is given after proper testing.

It is doubtful that rapid desensitization can be accomplished in the sensitive individual by the method presently practiced. Small dilute doses are given every 15 minutes for three-six hours. Often epinephrine is given in conjunction. I feel this is a hazardous procedure. I wonder how often this has been done with apparent impunity because of false positive skin tests. False positive reactions occur because of the trauma to the tissue from the large volume (0.1 cc) given as well as the E-E factor of the antitoxin which is so frequently used for testing. I do not feel there is proof that tachyphylaxis can be produced.

If or when human tetanus immune globulin becomes plentiful, it should be given instead of horse or bovine antitoxin.

### Summary

The ultimate goal in tetanus prophylaxis is to have immunization created by tetanus toxoid. Tetanus toxoid is free of animal protein. Sensitization to tetanus toxoid does occur but is uncommon. Until such time as all patients are immunized with tetanus toxoid or human tetanus immune globulin becomes plentiful, we are faced with the dilemma of using potentially dangerous and/or fatal foreign sera.

By proper testing, unnecessary withholding of antitoxin from patients can be prevented as well as the prevention of anaphylaxis from testing and treatment with foreign sera. To prevent the necessity of giving horse serum again in the future, tetanus toxoid immunization should be started along with the administration of tetanus antitoxin.

### Addendum

Since this article was accepted for publication, human tetanus antitoxin globulin has become commercially available.

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1815 N. Capitol Ave.
Indianapolis, Ind.

## From *The Journal* 50 Years Ago

. . . The form of Roentgen therapy knew as the "massive dose" has been used by some operators in the treatment of superficial malignancies, but this I deem an error, as in my experience such ailments are best treated by soft ray therapy. In the treatment of deep seated malignancies it is essential, of course, that the Roentgen rays reach the seat of the disease, wherever that may be, and to secure this necessary penetration requires very heavy dosage from high-vacuum tubes. Since such treatment must be administered through the skin, our efforts are necessarily limited by the intolerance of the skin to x-rays.

The soft rays are the most active in producing dermatitis; it is desirable therefore, to dispose of those rays, and yet permit the hard rays to reach and penetrate the tissues. This must be accomplished by means of a filter . . . .

* * * * *

. . . The substances most commonly used as filters are chamois skin, sole leather (either wet or dry) and aluminum. After some research, and using the three filters named, and finding each of them of insufficient obstructing power, two of them were combined, and in like manner I later came to using all three when a massive dose was to be administered to a deep malignancy. The filter I am employing under these conditions consists of 24 layers of chamois skin, dry; one layer of sole leather, wet; and three millimeters of aluminum. I am sure that any other substances would answer equally well, provided they offered approximately the same resistance to the rays. This is apparently a very heavy filter, and in fact it is a heavy filter as filters go . . . . A brief test with the fluoroscope shows that hard rays pass it in abundance . . . . James N. McCoy, M.D., "A Technic of the Roentgen Ray Massive Dose for Treatment of Deep Seated Carcinoma" *JISMA*, June, 1915.

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# Readership Survey

ALTHOUGH the returns could have been more numerous, the readership survey is proving to be a tremendous success. Questionnaires were still being received four months after the January issue was delivered, and after a slow start, added up to a presentable total.

There was a wealth of apparently carefully thought out, constructive criticism which characterized most replies and which filled some questionnaires to overflowing. Numerous compliments offered for various features and for the overall composition of *The Journal* as a whole were greatly appreciated by members of the staff.

Scientific articles, ISMA news, editorials, EKG of the Month and the Lieberman stories all placed high in the vote for "What feature do you like best in your journal?" Although this question was not answered by all the respondents, there was no item in *The Journal* that did not receive at least a few votes for "best."

And to prove the rule that it is not possible to construct a journal, or even to include one feature, that will please everyone, all the items that were voted "best" were also included in the list (although in considerably lesser numbers) of the feature "liked the least."

It was significant that whereas almost everyone voted for "best" — only a relatively few had an entry for "liked the least."

Practically every feature was also mentioned under the heading of "What would you like added," evidencing a desire on part of some of the readers to increase the bulk of many things already voted as "best." There were also requests for features which are not, or are only occasionally, included in *The Journal.* These requests are receiving consideration.

One gentleman voiced the wish of many a busy doctor when he listed under "What is missing that you would like added" the request "More time to read."

A large number of requests were received for the one form of scientific writing which *The Journal* has encouraged for years, but has received in small quantity — the Clinicopathologic Conference.

Professional pollsters rate a return of two percent on a survey like ours as average. Five percent is considered good and ten percent sensational. Our returns now stand at seven percent, better than good and almost excellent. The advice and help which will accrue to the Editorial Board and *The Journal* staff is rated as well above excellent. Many thanks are extended to

those who took the time and thought to complete the questionnaires.

Special thanks to the authors of the complimentary remark "I like it all" — appearing sometimes under "What do you like the best"; often under "What do you like the least" and also under "What would you like added" — right after the remark "No Change."

## Still the Missing Ingredient

Every year at this time we receive an appeal for assistance that we're happy to pass on to our readers. For — unlike so many appeals from charitable organizations — this is not an appeal for money.

Instead, The Epilepsy Foundation has asked us to ask you to join in its continuing search for the one ingredient most often found missing in the treatment of epilepsy. For according to the Foundation, it's the most important ingredient of all: understanding.

Medical progress in recent years has now made it possible for about 80% of all epilepsy patients to lead normal, active lives. All too often, though, public attitudes have lagged behind these medical advances. As a result, most epilepsy patients find themselves literally with no place to go: they can't work, because employers — and employees — are afraid of them.

Children with epilepsy are often barred from going to school with other kids their age. And in some states it is even a crime for a person with epilepsy to fall in love and marry — although the genetic factor in epilepsy has been shown to be insignificant.

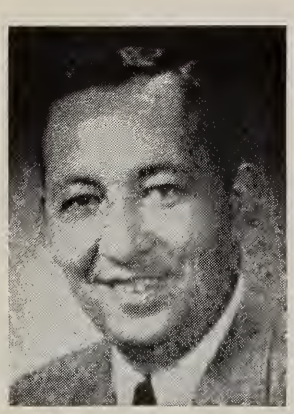
Through its research programs, the Foundation hopes to speed the day when it will be possible medically to prevent, and cure, epilepsy. In the meantime, it is relying on the good sense of the American people to remove the cruel stigma that has surrounded this disorder since ancient times and turned two million Americans into burdens on society. As a part of that effort, the Foundation is once again observing "National Epilepsy Information Month" during June.

During the next few weeks we will be featuring several articles that we hope will shed some much needed light on what has been called "the last of the hush-hush diseases." We hope you will read them, and that you will then do your part to help The Epilepsy Foundation in its mission of getting the facts about epilepsy before all of us.

# President's Page

## *Wanted—4,500 Unified Physicians*

As the days and weeks have passed, the American Medical Association has been in the forefront of the discussions in Washington concerning medicare. We know that the AMA is not going to change from its initial program as adopted at the special House of Delegates meeting earlier this year. And as we write this page, we are aware that the Senate Finance Committee has finished public hearings on the medicare bill, and now is in closed session.



Under the circumstances, I think it is imperative that we, as physicians, make every effort to face the present issues unified, and strong in that unity. It is imperative that members of our county medical societies inform themselves day by day on the issues and changes which are taking place, as this matter, which is of such a critical nature to our patients and to the profession, comes to the Senate floor for debate. It is imperative that our physician members inform their delegates and councilors of their feelings on these matters so that the Indiana State Medical Association can be constantly alert to the membership's desires, and act accordingly.

I would like to point out, too, that members of the association are being polled concerning their attitudes toward Social Security. We urge you to open your mail, read your mail and return the questionnaire which is from one of your senators. Undoubtedly, it will be used in Senate testimony as this body considers including physicians in the Social Security program.

Let me say again that if there was ever a time for unification in thought and action, it is now. I, personally, urge all of you to make it your individual objective to become more informed and to continue advising your congressman of your attitudes. Let your patients know, too, of your attitudes. Your opportunity here is unlimited. Use it to protect your right to practice medicine the way you know is best for your patients.



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# The Woman's Auxiliary

## REPORTS TO ISMA

We entertained out-of-state guests from Kentucky, Illinois, Michigan and Ohio at our House of Delegates meeting in April. We greatly enjoyed playing host to our neighboring states while taking pride in our own accomplishments. Soon after our own meeting, I was especially happy to visit Wisconsin and attend their meeting as it was presided over by a former classmate of mine.



At the Wisconsin meeting, Dr. Nicholas Nyaradi, Director of the School of International Studies, Bradley University, Peoria, Illinois, challenged the doctors and their wives to cease being naive and optimistic. He said the general public believes the doctors are fighting to save their fees and themselves whereas the battle of Medicare is only a small phase of the battle to preserve all individual freedom. An all-out nonpartisan, nonpolitical, educational effort of what freedom implies is necessary.

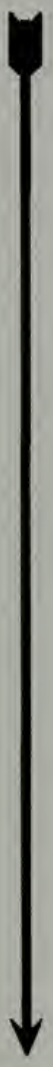
It should be stressed that the common man will suffer and lose "the wonderful medical care he now enjoys." The tendency to demand more and more from the government takes from the people and increases the size and power of government to a full-fledged Welfare State. Outstanding opportunities present themselves through the PTA, church groups, study groups and other organizations to inform Americans of their freedoms. Do Americans know their role? In whose interest should we continue to fight?

Dr. Nyaradi cited an instance in his own family. The bank where his 16-year-old son and nine-year-old daughter have savings accounts requested Social Security numbers for the children. Unbelieving, he called the bank and upon having the facts corroborated, asked if the numbers were to be tattooed on the left wrist? This was one of the first terrifying developments in Hungary, his native country, and to him signaled the encroachment of government on individual rights.

Food for thought over a two-days period, and a resolve to listen, learn and speak up.

Ruth V. Dunstone

# *ROSTER OF MEMBERS*

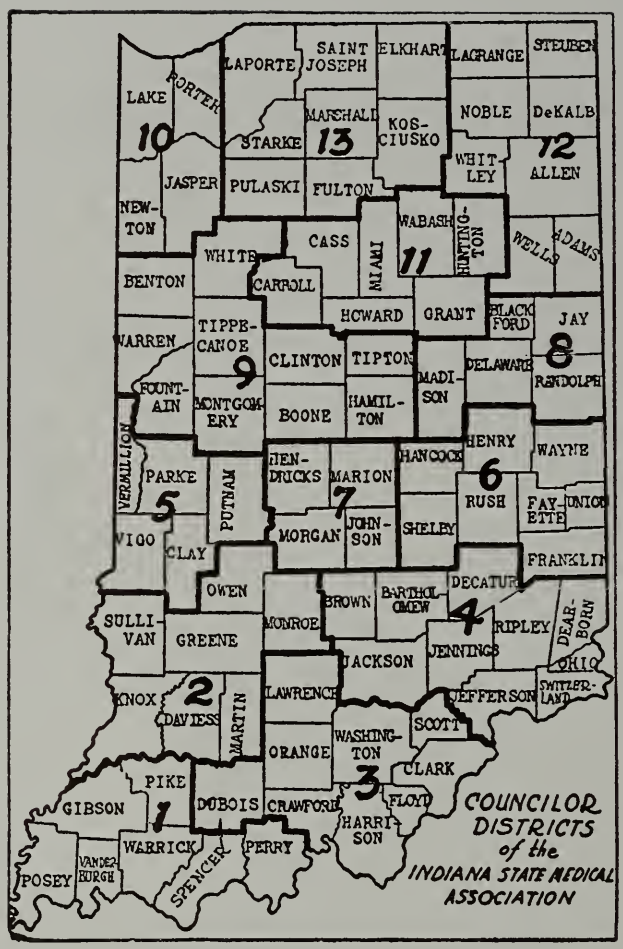


## Indiana State Medical Association
## and
## Woman's Auxiliary

June 1965

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# Membership Roster

## INDIANA STATE MEDICAL ASSOCIATION

Following is a list of paid-up members of the Indiana State Medical Association as of May 1, 1965.

The letter (S) following a name indicates that the physician is a senior member of his local society and of the Indiana State Medical Association. The letter (H) following a name indicates that the physician is an honorary member of his local society and the Indiana State Medical Association.

Physicians are listed in the county medical society in which they hold membership.

Names of members who have died during the year do not appear in this list.

If any errors are found in this list, please report them to THE JOURNAL, 3935 N. Meridian, Indianapolis 8, Indiana. The cooperation of members is urgently requested.

### ALPHABETICAL LIST OF MEMBERS

*For street addresses, see roster of members by counties, p. 33/555.*

| Name | City | County |
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| | **A** | |
| Aagesen, Walter J. | Anderson | Madison |
| Abell, Charles F. | Marion | Grant |
| Able, Walter | Columbus | Bartholomew-Brown |
| Abramson, Allan L. | Gary | Lake |
| Acher, Robert P. | Greensburg | Decatur |
| Acker, Robert B. (S) | South Bend | St. Joseph |
| Acre, Robert R. | Evansville | Vanderburgh |
| Adair, Samuel L. | Jeffersonville | Clark |
| Adair, William K. (S) | Crothersville | Jackson-Jennings |
| Adams, Julia L. | Muncie | Delaware-Blackford |
| Adams, E. Wade | Fort Wayne | Allen |
| Adams, Max R. | Flora | Carroll |
| Adams, William B. | Muncie | Delaware-Blackford |
| Adamski, Michael S. | Logansport | Cass |
| Addleman, Robert H. | Indianapolis | Marion |
| Ade, Charles H. | Lafayette | Tippecanoe |
| Ade, Mary Keller | Lafayette | Tippecanoe |
| Adkins, Harold C. | Indianapolis | Marion |
| Adler, David L. | Columbus | Bartholomew-Brown |
| Adler, Edmund R. | Dyer | Lake |
| Adler, Fred | Hammond | Lake |
| Adler, Raymond N. | Evansville | Vanderburgh |
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| Adye, Wallace M., Jr. | Evansville | Vanderburgh |
| Agana, Adriano A. | Gary | Lake |
| Ahlbrand, Roland C. | Fort Wayne | Allen |
| Aiken, Arthur F. | Fort Wayne | Allen |
| Aiken, Milo M. | Plainfield | Hendricks |
| Aiken, Nevin E. | Fort Wayne | Allen |
| Ake, Loren | Richmond | Wayne-Union |
| Akre, Philip R. | San Antonio, Texas | Marion |
| Albertson, Frank P. | Indianapolis | Marion |
| Albrecht, Willard H. | Indianapolis | Marion |
| Alcorn, Merritt O. | Madison | Jefferson-Switzerland |
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| Aldred, Allen W. | Indianapolis | Marion |
| Aldrich, Harry D. | Indianapolis | Marion |
| Aldrich, Howard | Indianapolis | Marion |
| Alexander, Ezra D. | Indianapolis | Marion |
| Alexander, John E. | Evansville | Vanderburgh |
| Alexander, Stephen J. | Crawfordsville | Montgomery |
| Alfano, Joseph E. | Hammond | Lake |
| Alfano, Paul A. | Gary | Lake |
| Alig, Vincent B. | Indianapolis | Marion |
| All, Barbara B. | Indianapolis | Marion |
| Allegretti, Michael L. | Munster | Lake |
| Allen, Donald R. | Evansville | Marion |
| Allen, George S. | Georgetown | Floyd |
| Allen, L. Howard | Bedford | Lawrence |
| Allen, Robert K. | Indianapolis | Marion |
| Allen, Robert T. | Richmond | Wayne-Union |
| Allen, William H. | Terre Haute | Vigo |
| Alley, Thomas W. | Indianapolis | Marion |
| Almquist, Carl O. (S) | Gary | Lake |
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| Altier, William H. | Fowler | Benton |
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| Amico, Pasquale J. | Gary | Lake |
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| Amstutz, H. Clair | Goshen | Elkhart |
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| Anderson, Garland D. | Fort Wayne | Allen |
| Anderson, James W. | Indianapolis | Marion |
| Anderson, John B. | Vincennes | Knox |
| Anderson, John T. | Zionsville | Marion |
| Anderson, Milton H. | Evansville | Vanderburgh |
| Anderson, Richard M. | Vincennes | Knox |
| Anderson, Robert C. | Richmond | Wayne-Union |
| Anderson, Walter C. | Terre Haute | Vigo |
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| Andrews, Fred B. | Columbus | Bartholomew-Brown |
| Andrews, Hugh K. | Franklin | Johnson |
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| Angeles, Uldarico A. | Gary | Lake |
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| Antes, Earl H. | Evansville | Vanderburgh |
| Antreasian, Berj | Indianapolis | Marion |
| Appel, Richard H. | Indianapolis | Marion |

| Name | City | County |
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| Apple, Eddie R. | Salem | Washington |
| Applegate, Albert E. | Frankfort | Clinton |
| Arata, James A. | Fort Wayne | Allen |
| Arata, Justin E. | Fort Wayne | Allen |
| Arata, Lucian A. | Shelbyville | Shelby |
| Arbeiter, Herbert I. | Munster | Lake |
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| Arbogast, Paul B. | Vincennes | Knox |
| Arbuckle, William E. (S) | Indianapolis | Marion |
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| Arford, John E. | Warsaw | Kosciusko |
| Arisman, Ralph K. | South Bend | St. Joseph |
| Arlook, Theodore D. | Elkhart | Elkhart |
| Armalavage, Leon J. | Gary | Lake |
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| Armington, Charles L. | Anderson | Madison |
| Armstead, John W. | Indianapolis | Marion |
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| Arnold, Aaron L. | Indianapolis | Marion |
| Arnold, Robert D. | Indianapolis | Marion |
| Aronson, Sidney S. | Indianapolis | Marion |
| Arrowsmith, James L. | Munster | Lake |
| Artis, Myrle E. | Kokomo | Howard |
| Artz, Richard W. | Angola | Steuben |
| Ash, Harold H. | W. Lafayette | Tippecanoe |
| Asher, Ernest O. (S) | New Augusta | Marion |
| Asher, James W. | New Augusta | Marion |
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| Atkins, Clarence C. | Rushville | Rush |
| Atwood, William H. | Elkhart | Elkhart |
| Ault, Carl H. | Kokomo | Howard |
| Ault, Roy J. | Terre Haute | Vigo |
| Aust, Charles H. | Ft. Wayne | Allen |
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| Ayres, Wendell W. | Marion | Grant |

## B

| | | |
|---|---|---|
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| Bacevich, Andrew J. | Hammond | Lake |
| Bachmann, Arnold J. | Indianapolis | Marion |
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| Baran, Charles | South Bend | St. Joseph |
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| Bard, Frank B. | Crothersville | Jackson-Jennings |
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| Batman, Gordon W. | Indianapolis | Marion |
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| Bauer, Thomas B. | Indianapolis | Marion |
| Baughn, William L. | Anderson | Madison |
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| Baxter, Harry R. | Seymour | Jackson-Jennings |
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| Bebensee, Donald L. | South Bend | St. Joseph |
| Bechtold, Samuel E. | South Bend | St. Joseph |
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| Bell, Robert L. | South Bend | St. Joseph |
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| Belt, James H. | Indianapolis | Marion |
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| Benchik, Frank A. | East Chicago | Lake |
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| Bender, Robert L. | Elkhart | Elkhart |
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| Berman, Jacob K. | Indianapolis | Marion |
| Bernard, Marvin R. | Gary | Lake |
| Berner, Herbert W., Jr. | Indianapolis | Marion |
| Bernoske, Daniel G. | Crown Point | Lake |
| Berry, John M. | Indianapolis | Marion |
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| Biegel, Angenieta A. | Indianapolis | Marion |
| Bierman, Gilbert H. | Fort Wayne | Allen |
| Bigler, Frederick W. | Goshen | Elkhart |
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| Billings, Elmer R. | Elkhart | Elkhart |
| Billingsley, John S. | Fort Wayne | Allen |
| Bills, R. James | Gary | Lake |
| Bills, Robert N. | Gary | Lake |
| Birdzell, John P. | Crown Point | Lake |
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| Blake, Albert L. | Indianapolis | Marion |
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| Bledsoe, James G. | New Castle | Henry |
| Blessinger, Louis H. | Corydon | Harrison-Crawford |
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| Bloom, George R. | Elkhart | Elkhart |
| Bloomer, Richard S. | Rockville | Parke-Vermillion |
| Bloss, Bryant A. | Evansville | Vanderburgh |
| Blossom, Paul W. | Richmond | Wayne-Union |
| Blum, Leon L. | Terre Haute | Vigo |
| Boaz, William D. | Wabash | Wabash |
| Bobb, Kenneth E. | Seymour | Jackson-Jennings |
| Bodnar, Leslie M. | South Bend | St. Joseph |
| Bogan, William C. | South Bend | St. Joseph |
| Bogardus, Carl R. | Austin | Scott |
| Boggs, Eugene F. | Indianapolis | Marion |
| Bohner, Caryle B. | Hidalgo, Mexico | Marion |
| Bolin, Robert C. | Lafayette | Tippecanoe |
| Boling, Frederick F. | Indianapolis | Marion |
| Boling, Grover C. | Indianapolis | Marion |
| Boling, Richard C. | Elkhart | Elkhart |
| Bolman, Ralph M. | Fort Wayne | Allen |
| Bomalaski, M. Donald | Indianapolis | Marion |
| Bomba, Brad J. | Bloomington | Owen-Monroe |
| Bombar, Leslie E. | Munster | Lake |

| Name | City | County |
|---|---|---|
| Bonaventura, Angelo P. | Highland | Lake |
| Bond, George S. (S) | Indianapolis | Marion |
| Bond, Virginia | Indianapolis | Marion |
| Bond, Walter C. | Clay City | Clay |
| Bond, William H. | Indianapolis | Marion |
| Bonsett, Charles A. | Indianapolis | Marion |
| Booher, Norman R. | Indianapolis | Marion |
| Booher, Olga Bonke | Indianapolis | Marion |
| Boone, Clarence W. | Gary | Lake |
| Boone, Robert D. | Evansville | Vanderburgh |
| Boonstra, Charles E. | Bluffton | Wells |
| Booth, Boynton H. | Indianapolis | Marion |
| Booth, Franklin M. | South Bend | St. Joseph |
| Booze, James H. | Bloomington | Owen-Monroe |
| Bopp, Henry W., Jr. | Terre Haute | Vigo |
| Bopp, James | Terre Haute | Vigo |
| Boren, Paul R. | Poseyville | Posey |
| Bornstein, Herschel | Gary | Lake |
| Borland, Raymond M. | Bloomington | Owen-Monroe |
| Borough, Lester D. | South Bend | St. Joseph |
| Bosch, Ralph | Seymour | Jackson-Jennings |
| Bosler, Howard A. | Westville | La Porte |
| Bossard, John W. | Fort Wayne | Allen |
| Boswell, Robert W. C. | Evansville | Vanderburgh |
| Botkin, Charles L. (S) | Muncie | Delaware-Blackford |
| Botkin, Charles T. | Muncie | Delaware-Blackford |
| Botkin, Clyde G. | Muncie | Delaware-Blackford |
| Boughman, Joe D. | Kokomo | Howard |
| Bowdoin, George E. (S) | Elkhart | Elkhart |
| Bowen, Gerald T. | Lawrenceburg | Dearborn-Ohio |
| Bowen, Otis R. | Bremen | Marshall |
| Bowers, Charles R. | Anderson | Madison |
| Bowers, Copeland C. | Kokomo | Howard |
| Bowers, Gah T. | Fort Wayne | Allen |
| Bowers, Garvey B. | Kokomo | Howard |
| Bowers, George W. | Fort Wayne | Allen |
| Bowers, John A. | Kokomo | Howard |
| Bowers, Jesse W. (S) | Fort Wayne | Allen |
| Bowman, Charles M. | Albion | Noble |
| Bowman, Geo. W. (S) | Indianapolis | Marion |
| Bowser, Philip G. | Goshen | Elkhart |
| Boyd, H. Clark | Terre Haute | Vigo |
| Boyd, Stella N. | Evansville | Vanderburgh |
| Boyer, Don W. | Lebanon | Boone |
| Boyer, Floyd A. | Indianapolis | Marion |
| Boyer, Grace B. | Marion | Grant |
| Boyle, Carroll L. | Poseyville | Posey |
| Boys, Fay F. | East Chicago | Lake |
| Boze, Robert L. | Berne | Adams |
| Bradley, Louis F. | Bluffton | Wells |
| Bradley, Richard V. | Kokomo | Howard |
| Brady, Samuel J. | Gary | Lake |
| Brady, Thomas A. | Indianapolis | Marion |
| Brakel, Frank J., Jr. | Evansville | Vanderburgh |
| Branco, Arthur M. | Munster | Lake |
| Brand, Anna | Gary | Lake |
| Brandman, Harry | Gary | Lake |
| Brandt, William E. | Fort Wayne | Allen |
| Brauchla, Carl H. (S) | Anderson | Madison |
| Brauer, Abraham A. | Westville | La Porte |
| Braun, Benjamin D. | East Chicago | Lake |
| Braunlin, Robert J. | Fort Wayne | Allen |
| Brayton, John R., Jr. | Pensacola, Fla. | Marion |
| Brayton, John R., Sr. | Indianapolis | Marion |
| Brayton, Lee | Indianapolis | Marion |
| Brazelton, Osborne T. (S) | Seal Beach, Calif. | Gibson |
| Brechtl, Harvey J. | South Bend | St. Joseph |
| Breedlove, C. Dane | Fairmount | Grant |
| Breneman, William L. | Fort Worth, Texas | Marion |
| Brennan, Bess B. | Hammond | Lake |
| Brennan, William C. | Whiting | Lake |
| Brenner, Howard B. | Munster | Lake |
| Bretz, John M. | Huntingburg | Dubois |
| Brickley, Harry D. | Indianapolis | Marion |
| Brickley, Richard A. | Indianapolis | Marion |
| Bridge, Barton C. | Lafayette | Tippecanoe |
| Bridges, Alvin L. | Anderson | Madison |
| Bridges, William L. | Fort Wayne | Allen |
| Bridwell, Edgar | Bedford | Lawrence |
| Briggs, Robert W. | Indianapolis | Marion |
| Brill, Joseph B. | Jeffersonville | Clark |
| Brillhart, James R. | Indianapolis | Marion |
| Brincko, John | Gary | Lake |
| Brink, Calvin C. (S) | Gary | Lake |
| Bristol, Henry M. S. | Terre Haute | Vigo |
| Britt, Robert L. | Evansville | Vanderburgh |
| Britton, Welbon D. | Montezuma | Parke-Vermillion |
| Brock, Earl E. (S) | Anderson | Madison |
| Brock, Joseph T. | New Castle | Henry |
| Brockman, Wilfred J. | Corydon | Harrison-Crawford |
| Brockmole, Arnold W. | Evansville | Vanderburgh |
| Brodie, Donald W. | Indianapolis | Marion |
| Broghammer, Benjamin J. | South Bend | St. Joseph |
| Bromley, Luman W. | Fort Wayne | Allen |
| Bronson, Paul J. | Terre Haute | Vigo |
| Brooks, Edwin A. | Evansville | Vanderburgh |
| Brooks, Fred R., Jr. | Indianapolis | Marion |
| Brooks, G. Tanner | Richmond | Wayne-Union |
| Brooks, Leonard C. | Warsaw | Kosciusko |
| Broomes, Edward L. C. | East Chicago | Lake |
| Brose, Paul E. | New York, N. Y. | Marion |
| Broshears, Kenneth P. | Linton | Greene |
| Brosius, Robert H. W. | Fort Wayne | Allen |
| Brown, Archie E. | Indianapolis | Marion |
| Brown, David E. | Indianapolis | Marion |
| Brown, DeWitt W. | Indianapolis | Marion |
| Brown, Earl R., Jr. | Indianapolis | Marion |
| Brown, Frances T. | Indianapolis | Marion |
| Brown, Frank M. | Indianapolis | Marion |
| Brown, Frederic W. | Fort Wayne | Allen |
| Brown, Garland R. | Fort Wayne | Allen |
| Brown, George E. | Greenwood | Johnson |
| Brown, George W. | Evansville | Vanderburgh |
| Brown, Gordon T. | Indianapolis | Marion |
| Brown, James C. | Valparaiso | Porter |
| Brown, John S. | Carlisle | Sullivan |
| Brown, Kenneth H. | New Albany | Floyd |
| Brown, Leland G. | Muncie | Delaware-Blackford |
| Brown, Leo R. | Gary | Lake |
| Brown, Marcel S. | Spencer | Owen-Monroe |
| Brown, Richard J. | Richmond | Wayne-Union |
| Brown, Robert M. | Marion | Grant |
| Brown, Robert R. | Terre Haute | Vigo |
| Brown, Stewart D. | Albany | Delaware-Blackford |
| Brown, Thomas M. | Muncie | Delaware-Blackford |
| Brown, Wendell E. | Indianapolis | Marion |
| Browning, James S. | Indianapolis | Marion |
| Browning, William M. | Indianapolis | Marion |
| Brownley, E. Jane | Indianapolis | Marion |
| Brubaker, Harold S. | Huntington | Huntington |
| Bruce, Reginald A. | Indianapolis | Marion |
| Brucker, Perry A. | Fort Wayne | Allen |
| Brueckmann, F. Robert | Indianapolis | Marion |
| Bruegge, Theodore J. | Kokomo | Howard |
| Bruetsch, Walter L. | Indianapolis | Marion |
| Bruner, Ralph W. (S) | Jeffersonville | Clark |
| Bryan, Franklin A. | Fort Wayne | Allen |
| Bryan, Paul E. | Madison | Jefferson-Switzerland |

| Name | City | County |
|---|---|---|
| Bryan, Robert E. | Kendallville | Noble |
| Bryan, Stanton L. | Evansville | Vanderburgh |
| Bryant, Edward G. | East Chicago | Lake |
| Buchanan, Wallace D. | South Bend | St. Joseph |
| Buche, Frederick P. (S) | Richmond | Wayne-Union |
| Buchman, Marshall H. | New Albany | Floyd |
| Buckingham, Richard E. | Bloomington | Owen-Monroe |
| Buckles, David L. | Anderson | Madison |
| Buckner, George D. | Fort Wayne | Allen |
| Buckner, Joy F. | Bluffton | Wells |
| Buddrus, David J. | Evansville | Vanderburgh |
| Buechler, William F. | Elwood | Madison |
| Buechner, Frederick W. | South Bend | St. Joseph |
| Buehner, Donald F. | Evansville | Vanderburgh |
| Buell, Forrest R. | Clay City | Clay |
| Bugh, Charles W. | Fairbanks, Alaska | Marion |
| Buhrmester, Harry C. | Lafayette | Tippecanoe |
| Bullers, Robert C. | Franklin | Johnson |
| Bullington, George E. | Whiteland | Johnson |
| Bunker, Ladoska Z. | North Manchester | Wabash |
| Burcham, James B. | Gary | Lake |
| Burdette, Harold F. | Indianapolis | Marion |
| Burger, Thomas C. | Evansville | Vanderburgh |
| Burghard, Rolla D. | Indianapolis | Marion |
| Burk, James M. | Decatur | Adams |
| Burket, Cecil R. | Bremen | Marshall |
| Burkhardt, Boyd A. | Tipton | Tipton |
| Burkhart, Charles A. | Fort Wayne | Allen |
| Burkle, Robert J. | Terre Haute | Vigo |
| Burks, Jess E. | Crawfordsville | Montgomery |
| Burnett, Arthur B. | New Castle | Henry |
| Burnett, Paul C. | Logansport | Cass |
| Burnikel, Ray H. | Evansville | Vanderburgh |
| Burns, John T. | Lafayette | Tippecanoe |
| Burns, Paul E. | Montpelier | Delaware-Blackford |
| Burress, Clyde R. | Evansville | Vanderburgh |
| Burwell, Stanley W. | Muncie | Delaware-Blackford |
| Bush, Charles E. | Kirklin | Clinton |
| Bush, Edward R. | Anderson | Madison |
| Bush, Hargis R. | Cannelton | Perry |
| Bush, Jack A. | Lafayette | Tippecanoe |
| Buslee, Roger M. | South Bend | St. Joseph |
| Bussard, Clifford F. (S) | South Bend | St. Joseph |
| Bussard, Frank W. | South Bend | St. Joseph |
| Butler, Joe B. | Crothersville | Jackson-Jennings |
| Butler, John O. | Indianapolis | Marion |
| Butler, Robert M. | Indianapolis | Marion |
| Butterfield, Robert M. | Muncie | Delaware-Blackford |
| Butts, Milton A. | South Bend | St. Joseph |
| Butz, Ralph O. | Muncie | Delaware-Blackford |
| Byrd, Ryland P. | Jeffersonville | Clark |
| Byrn, Howard W. (S) | Oxford | Floyd |
| Byrne, Louis | Bloomington | Owen-Monroe |
| Byrne, Robert J. | Bicknell | Knox |

## C

| | | |
|---|---|---|
| Cacia, John J. | Evansville | Vanderburgh |
| Cagle, Bob R. | New Palestine | Hancock |
| Cahn, Hugo M. | Indianapolis | Marion |
| Cahn, Peter H. | Indianapolis | Marion |
| Cahue, Antonio R. | Gary | Lake |
| Cain, David R. | New Castle | Henry |
| CaJacob, Melville E. | Terre Haute | Vigo |
| Caldwell, Marilyn R. | Indianapolis | Marion |
| Caldwell, Milton V. | Terre Haute | Vigo |
| Call, Herbert F. | Indianapolis | Marion |
| Call, William H. | Indianapolis | Marion |
| Callaghan, Winship C. | Greensburg | Decatur |
| Calli, Louis J. | North Vernon | Jackson-Jennings |
| Calvert, Raymond R. | Lafayette | Tippecanoe |
| Calvin, Helen M. | North Liberty | St. Joseph |
| Calvin, O. Walter | North Liberty | St. Joseph |
| Cameron, Don F. | Angola | Steuben |
| Cameron, Mary H. | Angola | Steuben |
| Campagna, Ettor A. | East Chicago | Lake |
| Campbell, H. Edwin, Jr. | Indianapolis | Marion |
| Campbell, John A. | Indianapolis | Marion |
| Campbell, Patrick B. | Elkhart | Elkhart |
| Campbell, Richard W. | Indianapolis | Marion |
| Campbell, Robert L. | Indianapolis | Marion |
| Campbell, Sam W. | Noblesville | Hamilton |
| Campbell, William T. | Bloomington | Owen-Monroe |
| Canaday, James W. (S) | Indianapolis | Marion |
| Canganelli, Vincent G. | Lafayette | Tippecanoe |
| Cannon, Daniel H. | New Albany | Floyd |
| Cantwell, Edgar R. | Vincennes | Knox |
| Caplin, Irvin | Indianapolis | Marion |
| Caplin, Samuel S. | Indianapolis | Marion |
| Carberry, George A. | Gary | Lake |
| Carbone, Joseph A. | Gary | Lake |
| Carey, J. Albert | Gary | Lake |
| Carlberg, Dale L. | Jeffersonville | Clark |
| Carlo, Ernest R. (S) | Fort Wayne | Allen |
| Carlson, Edward A. (S) | Peru | Miami |
| Carlson, Milton R. | Portage | Porter |
| Carlson, Norman R. | Michigan City | La Porte |
| Carlson, Ralph F. | Evansville | Vanderburgh |
| Carlyle, Ivan E. (S) | Michigantown | Clinton |
| Carmody, Raymond F. | Gary | Lake |
| Carneal, Thomas E. (S) | Winamac | Pulaski |
| Carnes, Edwin R. | Clarksville | Clark |
| Carney, Joel T. (S) | Jeffersonville | Clark |
| Carpenter, Bennie F. | Griffith | Lake |
| Carpenter, Donald J. | Terre Haute | Vigo |
| Carpenter, James B. | Lafayette | Tippecanoe |
| Carpenter, Ramesh S. | Garrett | DeKalb |
| Carpenter, Robert S. | W. Lafayette | Tippecanoe |
| Carpentier, James R. | La Porte | La Porte |
| Carr, Joseph H. | Henryville | Clark |
| Carrel, Francis E. | Frankfort | Clinton |
| Carroll, Bertha Rose | W. Lafayette | Tippecanoe |
| Carroll, John C. | Decatur | Adams |
| Carroll, Mary E. | Crown Point | Lake |
| Carson, Wayne | Indianapolis | Marion |
| Carter, Eunice M. | Noblesville | Hamilton |
| Carter, F. R. N. (S) | South Bend | St. Joseph |
| Carter, Fred S. | La Porte | La Porte |
| Carter, James E. | Indianapolis | Marion |
| Carter, Jean V. | Tipton | Tipton |
| Carter, John O. | Hobart | Lake |
| Cartwright, Emor L. (S) | Fort Wayne | Allen |
| Carty, Charles B. | Pekin | Washington |
| Casey, Stanley M. | Huntington | Huntington |
| Cassady, James V. | South Bend | St. Joseph |
| Cassady, John R. | South Bend | St. Joseph |
| Cast, William R. | Indianapolis | Marion |
| Castetter, Gregory K. | Anderson | Madison |
| Castro, Ignacio B., Jr. | Scottsburg | Scott |
| Cates, Jeryl R. | Evansville | Vanderburgh |
| Cattell, Lee M. | Kokomo | Howard |
| Cavins, Alexander W. | Terre Haute | Vigo |
| Caylor, Charles H. | Bluffton | Wells |
| Caylor, Harold D. | Bluffton | Wells |
| Caylor, Truman E. | Bluffton | Wells |
| Chael, Thomas C. | Munster | Lake |
| Challman, William B. | Mt. Vernon | Posey |
| Chambers, Alan R. | Fort Wayne | Allen |
| Chambers, Carol R. | Union City | Randolph |
| Chambers, Leroy B. | Union City | Randolph |
| Chamblee, Roland W. | South Bend | St. Joseph |
| Chandler, Leon H. | Goshen | Elkhart |
| Chappel, Alfred T. | Franklin | Johnson |
| Chase, James A. | Fort Wayne | Allen |

| Name | City | County |
|---|---|---|
| Chase, Thomas P. | Avon | Hendricks |
| Chattin, Herbert O. | Vincennes | Knox |
| Chattin, Robert E. | Loogootee | Daviess-Martin |
| Chattin, William R. | Indianapolis | Marion |
| Chattin, Vance J. | Washington | Daviess-Martin |
| Chau, Andrew Y. S. | Terre Haute | Vigo |
| Chavez, Mauro E. | Indianapolis | Marion |
| Cheesman, Donald D. | Danville | Hendricks |
| Chen, Ko K. | Indianapolis | Marion |
| Cheng, Sylvia F. | Logansport | Cass |
| Chernish, Stanley M. | Indianapolis | Marion |
| Chevalier, Robert B. | Indianapolis | Marion |
| Childs, Wallace E. | Madison | Jefferson-Switzerland |
| Chivington, Paul V. | Indianapolis | Marion |
| Choslovsky, Sydney | Gary | Lake |
| Christie, Marvin C. | Beech Grove | Marion |
| Christophel, Verna A. | Mishawaka | St. Joseph |
| Chroniak, Walter | Indianapolis | Marion |
| Chu, Johnson C. S. | Logansport | Cass |
| Chube, David D. | Gary | Lake |
| Church, Robert A. | Hammond | Lake |
| Clark, Charles M., Jr. | Indianapolis | Marion |
| Clark, George A. | Indianapolis | Marion |
| Clark, Ivan A. | Paoli | Orange |
| Clark, Jack P. | Syracuse | Elkhart |
| Clark, Joseph H. | Huntington | Huntington |
| Clark, Lawson J. | Indianapolis | Marion |
| Clark, Lintner E. | Muncie | Delaware-Blackford |
| Clark, Marion E. | Cambridge City | Henry |
| Clark, Robert M. | Muncie | Delaware-Blackford |
| Clark, Thomas W. | Evansville | Vanderburgh |
| Clark, William B., Jr. | Jeffersonville | Clark |
| Clark, William H. | South Bend | St. Joseph |
| Clark, William R. | Fort Wayne | Allen |
| Clarke, Elton R. (S) | Kokomo | Howard |
| Clarkson, Clarence G. | Liberty | Wayne-Union |
| Classen, Pete R. C. | Elkhart | Elkhart |
| Clay, Eleanor | Columbus | Bartholomew-Brown |
| Clevinger, William G. | Indianapolis | Marion |
| Cline, Kenneth L. | Wyatt | St. Joseph |
| Close, Gerald A. | S. Rhodesia, Africa | Marion |
| Close, W. Donald | Indianapolis | Marion |
| Clouse, John F. | Amarillo, Texas | Delaware-Blackford |
| Clouse, Paul A. | Evansville | Vanderburgh |
| Clunie, William A. | Huntington | Huntington |
| Coates, Jacqueline | Indianapolis | Marion |
| Cobb, Clarence M. | Logansport | Cass |
| Coble, Frank H. | Richmond | Wayne-Union |
| Cochran, Harry A., Jr. | Fort Wayne | Allen |
| Cochran, Robert B. | Muncie | Delaware-Blackford |
| Cockrum, William M. | Evansville | Vanderburgh |
| Coddington, Robert C. | Ft. Campbell, Ky. | Marion |
| Coffel, Melvin H. | Vincennes | Knox |
| Coggeshall, Warren E. | Indianapolis | Marion |
| Cohen, Hyman | Gary | Lake |
| Cohen, Irving | Plainfield | Hendricks |
| Cohn, Alvin F. | Indianapolis | Marion |
| Colbert, Richard M. | Largo, Fla. | Marion |
| Colbert, Ruth E. D. | Largo, Fla. | Marion |
| Cole, Ira | Lafayette | Tippecanoe |
| Coleman, Floyd B. | Waterloo | DeKalb |
| Coleman, Henry G. | Salem | Washington |
| Coleman, Joseph E. | Evansville | Vanderburgh |
| Colip, George D. | South Bend | St. Joseph |
| Collins, Hubert L. | Indianapolis | Marion |
| Collins, Jack T. | Bluffton | Wells |
| Collins, Margaret C. | Muncie | Delaware-Blackford |
| Collins, Robert C. | Indianapolis | Marion |
| Colosey, Frederick J. | South Bend | St. Joseph |
| Colvin, Robert C. | Newburgh | Warrick |
| Combs, Herman T. | Evansville | Vanderburgh |
| Combs, John H. | Evansville | Vanderburgh |
| Combs, Stuart R. | Terre Haute | Vigo |
| Comeau, William J. | Marion | Grant |
| Comer, Kenneth E. | Mooresville | Morgan |
| Compton, George L. | Tipton | Tipton |
| Compton, Walter A. | Elkhart | Elkhart |
| Conforti, Victor P. | Terre Haute | Vigo |
| Congleton, G. C. (S) | Terre Haute | Vigo |
| Conklin, James O. | Terre Haute | Vigo |
| Conklin, Raymond L. | Elkhart | Elkhart |
| Conley, John E. | Fort Wayne | Allen |
| Conley, Joseph L. (S) | Indianapolis | Marion |
| Conley, Thomas M. | Kokomo | Howard |
| Connell, Vactor O. | Bourbon | Marshall |
| Connelly, Jerry H. | Fort Wayne | Allen |
| Connelly, Richard D. | Fort Wayne | Allen |
| Connerley, Marion L. | Terre Haute | Vigo |
| Connoy, Andrew F. | Westfield | Hamilton |
| Connoy, Leo F. | Westfield | Hamilton |
| Conrad, Henry W. | Lawrenceburg | Dearborn-Ohio |
| Constan, Evan | Westville | La Porte |
| Conway, Chester C. | Indianapolis | Marion |
| Conway, Glenn | Indianapolis | Marion |
| Conway, Thomas J. | Terre Haute | Vigo |
| Cook, Charles E. | North Manchester | Wabash |
| Cook, Gordon C. | South Bend | St. Joseph |
| Cook, Melvin D. | New Albany | Floyd |
| Cook, Robert G. | Bluffton | Wells |
| Cooke, J. Kenneth | Indianapolis | Marion |
| Cookson, Lawrence U. | Indianapolis | Marion |
| Cooney, Charles J. | Fort Wayne | Allen |
| Coons, John D. (S) | Lebanon | Boone |
| Coons, Ritchie | Lebanon | Boone |
| Cooper, B. Trent | Roanoke | Huntington |
| Cooper, Harry L. (S) | South Bend | St. Joseph |
| Cooper, John F. | Muncie | Delaware-Blackford |
| Cooper, Leo K. | Gary | Lake |
| Cooper, Waller W. | Evansville | Vanderburgh |
| Cope, Stanton E. | Huntington | Huntington |
| Corcoran, Patrick J. V. | Evansville | Vanderburgh |
| Cormican, Herbert L. | Elkhart | Elkhart |
| Cornacchione, Matthew | Indianapolis | Marion |
| Cornell, Robert A. | Crawfordsville | Montgomery |
| Corpe, Kenneth F. | Rushville | Rush |
| Corrao, Gaetano | Gary | Lake |
| Corrao, Thomas J. | Jeffersonville | Clark |
| Corsentino, Bart E. | Vincennes | Knox |
| Cortese, James V. | Indianapolis | Marion |
| Cortese, Thomas A., Jr. | Indianapolis | Marion |
| Cortese, Thomas A. | Indianapolis | Marion |
| Costello, Albert J. | Hammond | Lake |
| Costin, Robert L. | Indianapolis | Marion |
| Cotter, Edward R. | Hammond | Lake |
| Cottrell, Robert F. | Fort Wayne | Allen |
| Coughenour, J. Robert | Indianapolis | Marion |
| Countryman, Frank W. | Indianapolis | Marion |
| Coursey, James O., Jr. | Plymouth | Marshall |
| Covalt, Wendell E. | Muncie | Delaware-Blackford |
| Covell, Harry M. | Auburn | DeKalb |
| Covey, Thomas J. | Valparaiso | Porter |
| Cox, Alfred C. | South Bend | St. Joseph |
| Cox, Leon T. | Richmond | Wayne-Union |
| Coyner, Alfred B. (S) | Lafayette | Tippecanoe |
| Craft, Kenneth L. (S) | Indianapolis | Marion |
| Craig, Alexander F. | Indianapolis | Marion |
| Craig, Harry L. | Huntingburg | Dubois |
| Craig, Reuben | Kokomo | Howard |
| Craig, Reuben A. (S) | Kokomo | Howard |

| Name | City | County |
|---|---|---|
| Craig, Richard M. | Fort Wayne | Allen |
| Craig, Robert A. | Syracuse | Elkhart |
| Crain, James W. | Williamsport | Fountain-Warren |
| Crampton, Chas. C. (S) | Delphi | Carroll |
| Crates, Gordon C. | Denver | Miami |
| Crawford, James H. | Evansville | Vanderburgh |
| Crawford, John A. | Indianapolis | Marion |
| Crawford, Theodore R. | Kokomo | Howard |
| Creek, Jean A. | Bloomington | Owen-Monroe |
| Cregger, Irby E. | Orlando AFB, Florida | Marion |
| Crevello, Albert J. | Evansville | Vanderburgh |
| Crimm, Paul D. | Evansville | Vanderburgh |
| Cripe, Earl P. | Bremen | Marshall |
| Cripe, William H. | Portland | Jay |
| Crise, John R. | Portage | Porter |
| Crist, John R. | Mt. Vernon | Posey |
| Crockett, Franklin S. (H) | W. Lafayette | Tippecanoe |
| Crockett, Wayne A. | Terre Haute | Vigo |
| Cron, William J. | Warsaw | Kosciusko |
| Cronin, H. Joseph | Indianapolis | Marion |
| Crosby, Reid C. | Indianapolis | Marion |
| Cross, David G. | Indianapolis | Marion |
| Crowder, James H. | Sullivan | Sullivan |
| Crudden, Charles H. | Evansville | Vanderburgh |
| Crum, Marion M. | Angola | Steuben |
| Culbertson, Carl S. | South Bend | St. Joseph |
| Culbertson, Clyde G. | Indianapolis | Marion |
| Cullen, P. Kent, Jr. | Indianapolis | Marion |
| Cullen, Paul K., Sr. | Indianapolis | Marion |
| Cullison, John L. | Muncie | Delaware-Blackford |
| Cullnane, Chris W. | Evansville | Vanderburgh |
| Culloden, William G. (S) | Indianapolis | Marion |
| Culp, John E. | Fort Wayne | Allen |
| Cunningham, Gene C. | Indianapolis | Marion |
| Cunningham, Robert D. | Marion | Grant |
| Cure, Charles W. | Indianapolis | Marion |
| Cure, Elmer T. | Muncie | Delaware-Blackford |
| Currie, Robert W. | Indianapolis | Marion |
| Curry, R. Louis | Indianapolis | Marion |
| Curtner, Myron L. (S) | Vincennes | Knox |
| Custer, Edward W. | South Bend | St. Joseph |
| Cuthbert, Marvin P. | Indianapolis | Marion |
| Cymbala, Bohdan | Henderson, Ky. | Vanderburgh |
| Czenkusch, Helen G. | Indianapolis | Marion |

## D

| | | |
|---|---|---|
| Daggy, James R. | Richmond | Wayne-Union |
| Dahling, Clemens W. | New Haven | Allen |
| Dahling, Fred W. | New Haven | Allen |
| Dainko, Alfred J. | East Chicago | Lake |
| Dale, Maxwell H. | Connersville | Fayette-Franklin |
| Daley, Edward H. | Indianapolis | Marion |
| Dallas, Fred R. | Indianapolis | Marion |
| Dallas, Mary E. | Indianapolis | Marion |
| Dalton, Naomi L. | Mysore State, India | Hendricks |
| Dalton, William W. | Indianapolis | Marion |
| Dalton, Wilson L. | Shelbyville | Shelby |
| Daly, Joseph M. | Indianapolis | Marion |
| Daniel, John C. (S) | Indianapolis | Marion |
| Daniel, Robert A. | Gary | Lake |
| Dannacher, William D. | Wabash | Wabash |
| Darling, Dorothy R. | Gary | Lake |
| Das, Amal K. | New Castle | Henry |
| Dasaro, George E. | Gary | Lake |
| Datzman, Basil J. | La Porte | La Porte |
| Datzman, Richard C. | Fort Wayne | Allen |
| Daugherty, Forest D. | Columbus | Bartholomew-Brown |
| Daugherty, Fred N. | Crawfordsville | Montgomery |
| Daugherty, William L. | Hutsonville, Ill. | Sullivan |
| Daves, W. Lawrence | Evansville | Vanderburgh |
| David, George J. | Muncie | Delaware-Blackford |
| Davidoff, Manuel A. | Fort Wayne | Allen |
| Davidson, Dale A. | Indianapolis | Marion |
| Davidson, Harold H. | Evansville | Vanderburgh |
| Davidson, N. Cort | Indianapolis | Marion |
| Davis, Bennie L. | Indianapolis | Marion |
| Davis, Carl M. | Valparaiso | Porter |
| Davis, Claude E. | Angola | Steuben |
| Davis, Edgar C. (S) | Muncie | Delaware-Blackford |
| Davis, Edward A. | South Bend | St. Joseph |
| Davis, Grayson B. | Lafayette | Tippecanoe |
| Davis, Howard B. | Lafayette | Tippecanoe |
| Davis, John A. | Flat Rock | Shelby |
| Davis, Joseph B. | Marion | Grant |
| Davis, Lloyd H. (S) | Madison | Jefferson-Switzerland |
| Davis, Margaret M. | Indianapolis | Marion |
| Davis, Marvin R. | Columbus | Bartholomew-Brown |
| Davis, Max D. | Evansville | Vanderburgh |
| Davis, Merrill S. (S) | Marion | Grant |
| Davis, Neal | Gary | Lake |
| Davis, Paul E. | Terre Haute | Vigo |
| Davis, Richard M. | Marion | Grant |
| Davis, Sam J. | Indianapolis | Marion |
| Davis, Thomas N. III | Hammond | Lake |
| Davis, William H. | New Market | Montgomery |
| Day, William D. C. | Seymour | Jackson-Jennings |
| Deal, Eleanor H. | Speedway City | Marion |
| Dean, Donald I. | Rushville | Rush |
| Dearmin, Robert M. | Indianapolis | Marion |
| DeArmond, Murray | Indianapolis | Marion |
| De Bois, Elon | Gary | Lake |
| DeBrota, John, Jr. | Kokomo | Howard |
| Deems, Myers B. | Evansville | Vanderburgh |
| Deever, John W. | Indianapolis | Marion |
| DeFries, John J. | New Paris | Elkhart |
| DeGrazia, Eugene J. | Valparaiso | Porter |
| Dehner, John R. | Langley AFB, Va. | Marion |
| Deitch, Robert D. | Indianapolis | Marion |
| DeMotte, C. Bowen | Greenwood | Marion |
| DeNaut, James F. | Knox | Starke |
| Denham, Robert H. | South Bend | St. Joseph |
| Dennison, Alfred D., Jr. | Indianapolis | Marion |
| Denny, Forrest L. | Indianapolis | Marion |
| Denny, James W. | Indianapolis | Marion |
| Denny, Melvin H. | Anderson | Madison |
| Denton, Larkin D. | Greentown | Howard |
| Denzer, Edward K. | Evansville | Vanderburgh |
| Denzer, William O. | Evansville | Vanderburgh |
| Deppe, Charles F. | Franklin | Johnson |
| Deren, Matthew J. | La Porte | La Porte |
| Derhammer, George L. | Brookston | Tippecanoe |
| Dester, Herbert E. (S) | Berne | Adams |
| DeTar, George B. (S) | Moore Haven, Fla. | Pike |
| Dettloff, Frederick R. | Greencastle | Putnam |
| Deupree, William D. | Shelbyville | Shelby |
| Deur, Julius J. | Lafayette | Tippecanoe |
| Deutsch, William | Muncie | Delaware-Blackford |
| DeVoe, Kenneth R. | South Bend | St. Joseph |
| DeWees, Dwight L. | Indianapolis | Marion |
| DeWester, Gerald M. | Indianapolis | Marion |
| Dian, August J. | Westville | La Porte |
| Dian, Julia K. | Westville | La Porte |
| Dickerson, W. Martin | Monticello | White |

| Name | City | County |
|---|---|---|
| Dickson, Carolyn L. | Indianapolis | Marion |
| Dickson, Dale D. | Greensburg | Decatur |
| Dieckman, Herbert S. | Evansville | Vanderburgh |
| Dierdorf, Fred W. | Terre Haute | Vigo |
| Dierolf, Edward J. | Gary | Lake |
| Dieter, William J. | Westville | La Porte |
| Dietl, Ernest L. | South Bend | St. Joseph |
| Dietz, David J. | Muncie | Delaware-Blackford |
| Dill, Charles W. | Beech Grove | Marion |
| Dill, Myron K. | Indianapolis | Marion |
| Dillard, Andrew G. | Indianapolis | Marion |
| Dillman, Carl E. | Corydon | Harrison-Crawford |
| Dillon, John F. | Indianapolis | Marion |
| Dilts, Robert L. | Indianapolis | Marion |
| Dimitroff, Lambro | Calumet City, Ill. | Lake |
| Dimmett, James D. | Chandler | Warrick |
| Dingle, Paul E. | Richmond | Wayne-Union |
| Dingley, Albert F. | South Bend | St. Joseph |
| Dininger, William S. | Winchester | Randolph |
| Dintaman, Paul G. | Indianapolis | Marion |
| Dirks, Kenneth R. | Ft. Detrick, Md. | Marion |
| Disney, Charles T. | Gary | Lake |
| Dittmer, Jack E. | Valparaiso | Porter |
| Dittmer, Thomas L. | Valparaiso | Porter |
| Dixon, Rex W. | Anderson | Madison |
| Doan, John E. | Decatur | Adams |
| Dodd, Robert D. | South Bend | St. Joseph |
| Dodd, Roberts K. | Evansville | Vanderburgh |
| Dodds, James U. | Hartford City | Delaware-Blackford |
| Dodds, Wemple | Crawfordsville | Montgomery |
| Doenges, James L. | Anderson | Madison |
| Doermann, Paul E. | Huntington | Huntington |
| Doherty, Raymond J. | Crown Point | Lake |
| Dolan, Patrick A. | Indianapolis | Marion |
| Doles, Ted S. | Middletown | Delaware-Blackford |
| Dolezal, Bernard J. | South Bend | St. Joseph |
| Donahue, Claude M. | Carmel | Hamilton |
| Donahue, Francis E. | Dublin | Henry |
| Donahue, George R. | Lafayette | Tippecanoe |
| Donahue, James M. | Indianapolis | Marion |
| Donaldson, Frank C. | Anderson | Madison |
| Donaldson, Miles W. | Marion | Grant |
| Donato, Albert M. | Indianapolis | Marion |
| Donchess, Joseph C. | Gary | Lake |
| Doneff, Ronald H. | Gary | Lake |
| Donnally, George A. | Portland | Jay |
| Donnelly, Everett F. | South Bend | St. Joseph |
| Doran, J. Hal | Indianapolis | Marion |
| Dormire, Robert D. | Warsaw | Kosciusko |
| Dorrance, Thomas O. | Bluffton | Wells |
| Dosado, Elpidio | Gary | Lake |
| Doss, Jerome F. | Forbes AFB, Kansas | Marion |
| Doughty, Samuel R., Jr. | Indianapolis | Marion |
| Douglas, William T. | Indianapolis | Marion |
| Dovey, Edward G. | Elkhart | Elkhart |
| Dowd, Joseph A. | Indianapolis | Marion |
| Dowell, Emil H. | Rockville | Parke-Vermillion |
| Downer, Luther H. | Evansville | Vanderburgh |
| Dragoo, John R. | Wabash | Wabash |
| Drake, Dale W. | Evansville | Vanderburgh |
| Drake, Ellery T. | Martinsville | Morgan |
| Drake, James R. | Anderson | Madison |
| Drake, John C. | Anderson | Madison |
| Drake, Marion C. | Elwood | Madison |
| Drennen, Robert V. | Anderson | Madison |
| Drew, Arthur L., Jr. | Indianapolis | Marion |
| Dreyer, Ralph W. | Richmond | Wayne-Union |
| Drummy, William W. | Terre Haute | Vigo |
| Dryden, Gale E. | Indianapolis | Marion |
| Dublin, Madeline P. | Francesville | Tippecanoe |
| DuBois, Charles C. (S) | Warsaw | Kosciusko |
| DuBois, Ramon B. | Lafayette | Tippecanoe |
| Dudgeon, Charles A. | Hartford City | Delaware-Blackford |
| Duemling, Arnold H. | Fort Wayne | Allen |
| Dugan, Thomas | Columbus | Bartholomew-Brown |
| Dugan, William M., Jr. | Indianapolis | Marion |
| Dukes, Betty | Dugger | Sullivan |
| Dukes, David A. | Tell City | Perry |
| Dukes, David J. | Corydon | Harrison-Crawford |
| Dukes, Frederic M. (S) | Dugger | Sullivan |
| Dukes, Joe E. | Dugger | Sullivan |
| Dulin, Basil B. | Anderson | Madison |
| Dumanian, Ara V. | Homewood, Ill. | Lake |
| Dunbar, Fred E. | Marion | Grant |
| Duncan, John S. | Gary | Lake |
| Duncan, Raymond | Bedford | Lawrence |
| Duncan, Stuart J. | Indianapolis | Marion |
| Duncan, William A. | Indianapolis | Marion |
| Dunham, Henry H. | Wabash | Wabash |
| Dunkin, Ramon S. | Indianapolis | Marion |
| Dunlap, D. Logan | South Bend | St. Joseph |
| Dunning, Thomas W. | Muncie | Delaware-Blackford |
| Dunstone, Harry C. | Fort Wayne | Allen |
| Dupler, Lee F. | Frankfort | Clinton |
| Durham, Lowell J. | La Porte | La Porte |
| Durham, Thomas E. | Elkhart | Elkhart |
| Durkee, Melvin S. | Evansville | Vanderburgh |
| Durkin, John W., Jr. | Evansville | Vanderburgh |
| Dusard, Joseph C. | Bedford | Lawrence |
| DuSold, Donald D. | Crown Point | Lake |
| Dutchess, C. Toney | Galveston | Cass |
| Dutchman, William R. | Muncie | Delaware-Blackford |
| Dyar, Edwin W. | Indianapolis | Marion |
| Dyar, Robert W. | Indianapolis | Marion |
| Dycus, Walter A. | Evansville | Vanderburgh |
| Dye, Cloyd L. | New Castle | Henry |
| Dye, William E. | Oakland City | Gibson |
| Dyer, George W. | Terre Haute | Vigo |
| Dyer, Wallace K. | Evansville | Vanderburgh |
| Dyke, Richard W. | Indianapolis | Marion |
| Dyken, Mark L. | Indianapolis | Marion |
| Dyken, Paul R. | Chicago, Ill. | Marion |
| Dykhuizen, Theodore A. | Frankfort | Clinton |
| Dzenitis, Andrievs J. | Indianapolis | Marion |
| Dziabis, Marvin D. | Indianapolis | Marion |

## E

| | | |
|---|---|---|
| Eades, R. Charles | South Bend | St. Joseph |
| Earl, Max M. | Kokomo | Howard |
| Earp, Evanson B. | Indianapolis | Marion |
| Easter, James N. | New Castle | Henry |
| Eastman, Joseph R., Jr. | Indianapolis | Marion |
| Eaton, Edwin R. | Indianapolis | Marion |
| Eaton, Lyman D. | Indianapolis | Marion |
| Eaton, Marion J. | Lafayette | Tippecanoe |
| Ebbinghouse, Tom | Richmond | Wayne-Union |
| Ebert, J. Wayne | Indianapolis | Marion |
| Eberwein, John H. (S) | Indianapolis | Marion |
| Ebin, Judah L. | Evansville | Vanderburgh |
| Echeverria, Rodolfo E. | Elkhart | Elkhart |
| Echsner, Herman J. | Columbus | Bartholomew-Brown |
| Echt, Charles R. | Indianapolis | Marion |
| Eckert, Russell A. | Logansport | Cass |
| Edmonds, Kendrick | Bedford | Lawrence |
| Edwards, Bernard E. | Tacoma, Wash. | St. Joseph |
| Edwards, Edward T. | Vincennes | Knox |
| Edwards, Henry G. | Terre Haute | Vigo |
| Edwards, William F. | New Albany | Floyd |
| Edwards, Wendell L. | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| Egan, Sherman L. | South Bend | Marion |
| Egan, William P. | Indianapolis | Marion |
| Egbert, Herbert L. | Indianapolis | St. Joseph |
| Egger, Ross L. | Middletown | Delaware-Blackford |
| Eggers, Ernest L. (S) | Hammond | Lake |
| Eggers, Henry W. | Hammond | Lake |
| Eggers, Richard R. | Crawfordsville | Montgomery |
| Egnatz, Charles D. | Schererville | Lake |
| Egnatz, Nicholas | Hammond | Lake |
| Ehrich, William S. (S) | Manning, S. Carolina | Vanderburgh |
| Eicher, Palmer O. | Indianapolis | Marion |
| Eiler, Paul A. | North Manchester | Wabash |
| Eisaman, Jack L. | Bluffton | Wells |
| Eisenberg, David A. | Martinsville | Morgan |
| Eisterhold, John A. | Evansville | Vanderburgh |
| Eldridge, Gail E. | Indianapolis | Marion |
| Elkins, James P. | Indianapolis | Marion |
| Elledge, Ray (S) | Hammond | Lake |
| Elleman, John H. | Kokomo | Howard |
| Ellett, John, Jr. | Coatesville | Putnam |
| Elliott, Paul W. | Lafayette | Tippecanoe |
| Elliott, Thomas A. | Elkhart | Elkhart |
| Ellis, Charles R. | Indianapolis | Marion |
| Ellis, Davis W., Jr. | Rushville | Rush |
| Ellis, Forrest D. | North Vernon | Jackson-Jennings |
| Ellis, George M. | Connersville | Fayette-Franklin |
| Ellis, Lyman H. | Lizton | Hendricks |
| Ellis, Seth W. | Anderson | Madison |
| Ellis, William N. | Indianapolis | Marion |
| Elshout, Clem H. | Ann Arbor, Mich. | La Porte |
| Elsten, Aubrey, W. | Anderson | Madison |
| Elston, Lynn W. (S) | Fort Wayne | Allen |
| Elston, Ralph W. | Fort Wayne | Allen |
| Elward, Carl J. | Wabash | Wabash |
| Ely, Cecil W. | Jeffersonville | Clark |
| Emenhiser, Donald C. | New Haven | Allen |
| Emenhiser, John L. | Fort Wayne | Allen |
| Emery, Charles B. | Bedford | Lawrence |
| Emery, Charles B., Jr. | Bloomington | Owen-Monroe |
| Emhardt, John T. | Indianapolis | Marion |
| Emhardt, John W. A. (S) | Indianapolis | Marion |
| Emme, Richard W. | Harlan | Allen |
| Endicott, Wayne H. | Greenfield | Hancock |
| Engel, Edgar L. | Evansville | Vanderburgh |
| Engel, Howard R. | South Bend | St. Joseph |
| Engeler, James E. | Lafayette | Tippecanoe |
| Engle, Russell B. | Winchester | Randolph |
| Engleman, Reinhold | Fort Wayne | Allen |
| English, Hubert M. | Gary | Lake |
| English, John P. | South Bend | St. Joseph |
| Ensey, Philip L. | Terre Haute | Vigo |
| Entner, Charles L. | Dunkirk | Jay |
| Episcopo, Arsenius R. | Salem | Washington |
| Epps, James H. | Fort Wayne | Allen |
| Erdel, Milton W. | Frankfort | Clinton |
| Erehart, Mark G. (S) | Huntington | Huntington |
| Erhart, Hubert | Ferdinand | Dubois |
| Ericksen, Lester G. | South Bend | St. Joseph |
| Erickson, Gustaf W. | South Bend | St. Joseph |
| Ericson, Harold L. | Windfall | Tipton |
| Ericson, Homer S. | Kokomo | Howard |
| Erwin, W. Robert | La Porte | La Porte |
| Eshelman, Henry R. | Monterey | Pulaski |
| Eskew, Kenneth W. | Sullivan | Sullivan |
| Espino, Jose C. | Munster | Lake |
| Espy, Theodore R. | Gary | Lake |
| Eugenides, Tatiana | Highland | Lake |
| Evans, Daniel R. | Indianapolis | Marion |
| Evans, Frederick H. | Indianapolis | Marion |
| Evans, Frederick J. | Clinton | Parke-Vermillion |
| Evans, Paul V. | Indianapolis | Marion |
| Everly, Ralph V. | Indianapolis | Marion |
| Eviston, John B. (S) | Huntington | Huntington |
| Ewer, Robert W. | Evansville | Vanderburgh |
| Ewing, Nathaniel D. | Vincennes | Knox |

## F

| | | |
|---|---|---|
| Fadell, Matthew J. | Gary | Lake |
| Fadul, Armand | Crown Point | Lake |
| Failey, Robert B., Jr. | Indianapolis | Marion |
| Faith, Ira L. | Evansville | Vanderburgh |
| Fargher, Francis M. | Michigan City | La Porte |
| Farid, Rahim S. | Brazil | Clay |
| Farner, James E. | Mishawaka | St. Joseph |
| Farnsworth, Samuel A. | La Porte | La Porte |
| Farquhar, John S., Jr. | Fort Wayne | Allen |
| Farr, James C. | Bloomington | Owen-Monroe |
| Farrell, John J., Jr. | Greenfield | Hancock |
| Farrell, Joseph T. | Indianapolis | Marion |
| Farrell, Thomas E. | Kokomo | Howard |
| Farris, John J. | Washington | Daviess-Martin |
| Faul, Henry J. | Evansville | Vanderburgh |
| Faulkner, Donald J. | Hobart | Lake |
| Fausset, C. Basil | Indianapolis | Marion |
| Faust, Howard M., Jr. | Anderson | Madison |
| Faw, Melvin L. | Evansville | Vanderburgh |
| Fechtman, William F. | Indianapolis | Marion |
| Fedor, Thomas A. | East Chicago | Lake |
| Feeney, Martin T. | Indianapolis | Marion |
| Feferman, Martin E. | South Bend | St. Joseph |
| Feinberg, Irwin I. | Whiting | Lake |
| Feinn, Harry S. | La Porte | La Porte |
| Feldman, Max | South Bend | St. Joseph |
| Feldner, Ronald P. | Calumet City, Ill. | Lake |
| Fell, Robert M. | Rosedale | Parke-Vermillion |
| Fenneman, Robert J. | Evansville | Vanderburgh |
| Ferguson, Arthur N. | Fort Wayne | Allen |
| Ferguson, Donald H. | Anderson | Madison |
| Ferguson, William B. | Lafayette | Tippecanoe |
| Ferrara, Donald W. | Peru | Miami |
| Ferrara, Joseph F. | Franklin | Johnson |
| Ferrara, Samuel J. | Peru | Miami |
| Ferrell, Mars B. | Fortville | Madison |
| Ferry, Francis A. | Indianapolis | Marion |
| Ferry, John L. | Whiting | Lake |
| Ferry, Paul W. (S) | Kokomo | Howard |
| Fessler, Gordon S. | Rising Sun | Dearborn-Ohio |
| Fetrow, Kenneth O. | Munster | Lake |
| Fichman, Abraham M. | Fort Wayne | Allen |
| Fickas, Dallas | Evansville | Vanderburgh |
| Fiederlein, Frederick J. | Muncie | Delaware-Blackford |
| Fields, Don C. | Lafayette | Tippecanoe |
| Fields, Donald L. | Kokomo | Howard |
| Filipek, Walter J. | South Bend | St. Joseph |
| Finfrock, James D. | Elkhart | Elkhart |
| Finneran, Joseph C. | Indianapolis | Marion |
| Fipp, August L. | Rome City | Noble |
| Firestein, Ben Z. | South Bend | St. Joseph |
| Firestein, Ray | South Bend | St. Joseph |
| Fisch, Charles | Indianapolis | Marion |
| Fischer, A. Alan | Indianapolis | Marion |
| Fischer, Burnell | Hammond | Lake |
| Fischer, Carlton N. | La Porte | La Porte |
| Fischer, Warren E. | Anderson | Madison |
| Fish, Clyde M. (S) | Edwardsburg, Mich. | St. Joseph |
| Fish, Edson C. | South Bend | St. Joseph |
| Fisher, Gerald E. | Ippy, Central African Republic | Marion |
| Fisher, Henry | Marion | Grant |
| Fisher, John E. | Attica | Fountain-Warren |

| Name | City | County |
|---|---|---|
| Fisher, John E. | New Castle | Henry |
| Fisher, Lawrence F. (S) | South Bend | St. Joseph |
| Fisher, Walter S. | Columbus | Bartholomew-Brown |
| Fisher, William C. | Evansville | Vanderburgh |
| Fitzgerald, Brice E. | W. Lafayette | Tippecanoe |
| Fitzgerald, William J. | Indianapolis | Marion |
| Fitzpatrick, H. W. (S) | Elwood | Madison |
| Fitzpatrick, James S. | Portland | Jay |
| Fitzpatrick, William J. | Hammond | Lake |
| Flack, Russell A. | Lafayette | Tippecanoe |
| Flaherty, Robert A. | Fort Wayne | Allen |
| Flanagan, Estle P. (S) | Walton | Cass |
| Flanagan, Paul M. | Indianapolis | Marion |
| Flanders, Robert, Jr. | Indianapolis | Marion |
| Flanigan, Meredith B. | Indianapolis | Marion |
| Flannigan, Harley F. | LaGrange | LaGrange |
| Fleischer, Jacob C. | East Chicago | Lake |
| Fleischl, Herbert | Indianapolis | Marion |
| Flick, John J. | Indianapolis | Marion |
| Flora, Fred W. | Frankfort | Clinton |
| Flora, Joseph O. | Indianapolis | Marion |
| Fogel, Ernest J. | Logansport | Cass |
| Folck, John K. | Princeton | Gibson |
| Foley, Hansel O. | South Bend | St. Joseph |
| Folkening, Norval C. | Indianapolis | Marion |
| Foltz, Lloyd E. | Brownsburg | Hendricks |
| Fong, Theodore C. C. | Madison | Jefferson-Switzerland |
| Forbes, Robert S. | Indianapolis | Marion |
| Forbes, Violet Crabbe | Wolcott | White |
| Foreman, Walter A. | Brookville | Fayette-Franklin |
| Forrest, O. Norman, Jr. | South Bend | St. Joseph |
| Forry, Frank (S) | Spartanburg, N. Car. | Marion |
| Forsee, Norman E. | Jeffersonville | Clark |
| Fortuna, Frank W. | Indianapolis | Marion |
| Fosbrink, Ephraim L. | Syracuse | Elkhart |
| Fosgate, Harold L. | Indianapolis | Marion |
| Foster, Douglas L. | Philadelphia, Pa. | Lake |
| Foster, John A. | Indianapolis | Marion |
| Foster, Lee N. | Indianapolis | Marion |
| Foster, Ray D. | Indianapolis | Marion |
| Foster, Ray T. | New Castle | Henry |
| Foster, Robert H. K. | Franklin | Johnson |
| Fountaine, Thomas J. | Bedford | Lawrence |
| Fouts, Paul J. | Indianapolis | Marion |
| Fowler, R. Ross | Bloomington | Owen-Monroe |
| Fox, C. Philip | Washington | Daviess-Martin |
| Fox, Jack M. | Munster | Lake |
| Fox, Richard F. | Lafayette | Tippecanoe |
| Foy, Thomas D. | Fort Wayne | Allen |
| Frable, Frank L., Jr. | Lawrenceburg | Dearborn-Ohio |
| Frahm, Charles | East Chicago | Lake |
| France, Lloyd C. | Plymouth | Marshall |
| Frank, Herbert | South Bend | St. Joseph |
| Frank, John R. (S) | Valparaiso | Porter |
| Frank, Lyall, Jr. | South Bend | St. Joseph |
| Frank, Lyall L. | South Bend | St. Joseph |
| Franke, Gordon R. | Fort Wayne | Allen |
| Frankhouser, Charles M. A., Jr. | Fort Wayne | Allen |
| Franklin, William L. | Indianapolis | Marion |
| Frankowski, Clementine | Whiting | Lake |
| Frantz, Mount E. | Danville | Hendricks |
| Franz, Sherman G. | Indianapolis | Marion |
| Frasch, Mahlon G. | Lafayette | Tippecanoe |
| Frash, DeVon W., Jr. | South Bend | St. Joseph |
| Frash, DeVon W. | South Bend | St. Joseph |
| Frazier, John L. | Kokomo | Howard |
| Freeborn, Warren S., Jr. | Oaklandon | Hancock |
| Freeby, C. William | Decatur | Adams |
| Freed, Carl A. | Indianapolis | Marion |
| Freed, John E., Jr. | Terre Haute | Vigo |
| Freeland, Bill E. | Batesville | Ripley |
| Freeman, Leslie W. | Indianapolis | Marion |
| Freeman, Max E. | Indianapolis | Marion |
| French, Richard N. | Indianapolis | Marion |
| Fretz, Richard C. | Kokomo | Howard |
| Frey, Harley H., Jr. | Lafayette | Tippecanoe |
| Frey, William B. | South Bend | St. Joseph |
| Friedman, Isadore E. | Hammond | Lake |
| Friedman, Morris S. | South Bend | St. Joseph |
| Frith, Louis G. | South Bend | St. Joseph |
| Fromhold, Willis A. | Indianapolis | Marion |
| Frost, Robert J. | Michigan City | La Porte |
| Fry, Robert D. | Indianapolis | Marion |
| Fuelling, James L. | Marion | Grant |
| Fugelso, Erling S. | Indianapolis | Marion |
| Fullam, Richard G. | Fort Wayne | Allen |
| Fuller, Robert G. | Columbus | Bartholomew-Brown |
| Fulper, James C. | Indianapolis | Marion |
| Fulton, William H. | Indianapolis | Marion |
| Fultz, Roy L. | Salem | Washington |
| Fundenberger, Martin | Indianapolis | Marion |
| Furr, Jack D. | Kingman | Fountain-Warren |
| Futterknecht, James O. | Elkhart | Elkhart |

## G

| | | |
|---|---|---|
| Gabe, William E. (S) | Orinda, Calif. | Marion |
| Gabovitch, Edward R. | Indianapolis | Marion |
| Gabrielsen, Ted H. | International P.O. Box 1192, Seoul, Korea | Marion |
| Gaddy, Euclid T. | Indianapolis | Marion |
| Gaddy, Nelson D. | Indianapolis | Marion |
| Gaffney, Raymond | South Bend | St. Joseph |
| Gahimer, Joe E. | Anderson | Madison |
| Gailey, Ivan L. | Clinton | Parke-Vermillion |
| Galante, Vincent J. | Gary | Lake |
| Galbreth, Jesse P. (S) | Burnettsville | White |
| Galliher, Marjorie J. | Muncie | Delaware-Blackford |
| Gallinatti, John J. | Gary | Lake |
| Galloway, John A. | Indianapolis | Marion |
| Gambill, J. Randolph | Indianapolis | Marion |
| Gambill, William D. | Indianapolis | Marion |
| Gammieri, Robert L. | Indianapolis | Marion |
| Gammell, Lindley L. | Columbus | Bartholomew-Brown |
| Ganser, Ralph V. | South Bend | St. Joseph |
| Ganser, Richard A. | Mishawaka | St. Joseph |
| Gante, Henry W. (S) | Anderson | Madison |
| Ganz, Max | Marion | Grant |
| Garceau, George J. | Indianapolis | Marion |
| Gard, Daniel A. | Indianapolis | Marion |
| Gardiner, H. Glenn | Munster | Lake |
| Gardiner, Sprague H. | Indianapolis | Marion |
| Gardner, Austin L. | Indianapolis | Marion |
| Gardner, Buckman | Indianapolis | Marion |
| Gardner, Melvin D. | Michigan City | La Porte |
| Gardner, Russell A. | Michigan City | La Porte |
| Garfield, Martin D. | Indianapolis | Marion |
| Garland, Edgar A. | Evansville | Vanderburgh |
| Garling, Luvern C. | Muncie | Delaware-Blackford |
| Garner, W. Stanley | Indianapolis | Marion |
| Garner, William H., Jr. | New Albany | Floyd |
| Garner, William H., Sr. (S) | New Albany | Floyd |
| Garrett, John D. (S) | Indianapolis | Marion |
| Garrett, Robert A. | Indianapolis | Marion |
| Garrison, James L. | Cumberland | Hancock |
| Garrison, Leon J. | Gas City | Grant |
| Garst, Garland R. | Evansville | Vanderburgh |
| Garton, Harry W. | Fort Wayne | Allen |
| Garvin, Donald B. | Brazil | Clay |

| Name | City | County |
|---|---|---|
| Gastineau, David C. | Fort Wayne | Allen |
| Gates, George E. | South Bend | St. Joseph |
| Gattman, George B. | Elkhart | Elkhart |
| Gatzimos, Christos D. | Logansport | Cass |
| Gaul, L. Edward | Evansville | Vanderburgh |
| Gaunt, Everett W. | Alexandria | Madison |
| Geckler, Charles E. | Muncie | Delaware-Blackford |
| Geick, Raymond G. | Fort Branch | Gibson |
| Geider, Roy A. | Indianapolis | Marion |
| Geiger, Dillon D. | Bloomington | Owen-Monroe |
| Geisinger, Lewis N. (S) | Auburn | De Kalb |
| Geisler, Hans E. | New York, N. Y. | Marion |
| Geller, Samuel | Evansville | Vanderburgh |
| Genna, Mary E. Miller | Hale's Corners, Wisc. | Marion |
| Gentile, John P. | New Albany | Floyd |
| Gentile, Jonathan P. | Fort Wayne | Allen |
| George, Charles L. | Indianapolis | Marion |
| Gerding, William J. | Fort Wayne | Allen |
| Gerig, Eldon L. | Mishawaka | St. Joseph |
| Gerrish, Donald A. | Terre Haute | Vigo |
| Gery, Richard E. | Lafayette | Tippecanoe |
| Getty, William H. | Evansville | Vanderburgh |
| Gevirtz, Milton B. | Munster | Lake |
| Geyer, Joseph H. | New Albany | Floyd |
| Gibbs, Charles M. (S) | Warren | Hancock |
| Gibbs, Joseph W. | Martinsville | Hendricks |
| Gibson, Alois E. | Richmond | Wayne-Union |
| Gibson, Greta Maxine | Indianapolis | Marion |
| Gibson, Robert K. | Muncie | Delaware-Blackford |
| Gick, Herman H. (S) | Indianapolis | Marion |
| Giffin, Charles S. | Fort Wayne | Allen |
| Gifford, Fred E. | Indianapolis | Marion |
| Gilbert, Robert G. | Tell City | Perry |
| Gill, Dee D. | Leesburg | Kosciusko |
| Gill, D. Richard | Huntington | Huntington |
| Gill, Thomas A. | Muncie | Delaware-Blackford |
| Gilles, Pierre | Gary | Lake |
| Gillespie, Charles F. | Indianapolis | Marion |
| Gillespie, Garland R. | Brownstown | Jackson-Jennings |
| Gillespie, Jacob E. | Indianapolis | Marion |
| Gilliland, John E. | Honduras, C. America | Marion |
| Gillim, Parvin D. | Indianapolis | Marion |
| Gillotte, Joseph P. | Tampa, Fla. | Vigo |
| Gillum, Eugene M. | Portland | Jay |
| Gilman, Marcus M. | South Bend | St. Joseph |
| Gilmore, Robert W. | Michigan City | La Porte |
| Gilmore, Russell A. (S) | Michigan City | La Porte |
| Gingerick, Charles M. | Liberty Center | Wells |
| Ginsberg, Stewart T. | Indianapolis | Marion |
| Giorgio, Douglas J. | Evansville | Vanderburgh |
| Girod, Arthur H. | Decatur | Adams |
| Gish, Howard M. | Brookston | Tippecanoe |
| Gitlin, Max M. | Bluffton | Wells |
| Gitlin, William A. | Bluffton | Wells |
| Given, Gilbert Z. | East Chicago | Lake |
| Glackman, John C., Jr. | Rockport | Spencer |
| Gladstone, Naf H. | Fort Wayne | Allen |
| Glassley, Stephen H. | Fort Wayne | Allen |
| Glendening, John L. (S) | Indianapolis | Marion |
| Glendening, Richard L. | Logansport | Cass |
| Glock, Homer E. (S) | Fort Wayne | Allen |
| Glock, Maurice E. | Fort Wayne | Allen |
| Glock, Wayne R. | Fort Wayne | Allen |
| Glover, John L. | Indianapolis | Marion |
| Glover, William J. | Gary | Lake |
| Gobbel, Novy E. (S) | English | Harrison-Crawford |
| Goebel, Carl W. | Fort Wayne | Allen |
| Godersky, George E. | South Bend | St. Joseph |
| Goethals, Charles J. | Mishawaka | St. Joseph |
| Gold, Marvin E. | Valparaiso | Porter |
| Goldberg, Harold B. | Gary | Lake |
| Golden, W. Y. | Jeffersonville | Clark |
| Goldenburg, Mitchell E. | Whiting | Lake |
| Golding, Robert F. | Gary | Lake |
| Goldman, Samuel | Indianapolis | Marion |
| Goldsmith, David A. | Marion | Grant |
| Goldstone, Adolph | Gary | Lake |
| Goldstone, Arthur | Gary | Lake |
| Goldstone, Joseph | Gary | Lake |
| Goldstone, Robert J. | Gary | Lake |
| Goldstone, Sidney R. | Gary | Lake |
| Golper, Marvin N. | Kokomo | Howard |
| Good, Richard P. | Kokomo | Howard |
| Goodman, Eli | Charlestown | Clark |
| Goodman, Hubert T. | Terre Haute | Vigo |
| Goodrum, William R. | Cayuga | Parke-Vermillion |
| Goodwin, Thomas | Gary | Lake |
| Gootee, Francis H. | Jasper | Dubois |
| Gootee, Thomas H. | Jasper | Dubois |
| Gordon, Joseph L. | Wheeler | Porter |
| Gormley, Joseph J. | Indianapolis | Marion |
| Gosman, James H. | Indianapolis | Marion |
| Gossard, Meredith B. | Tipton | Tipton |
| Gossom, Donn R. | Terre Haute | Vigo |
| Gould, John C. | Fort Wayne | Allen |
| Gourieux, E. De Verre | Evansville | Vanderburgh |
| Govorchin, Alexander | East Chicago | Lake |
| Graber, Benjamin R. | Waterloo | DeKalb |
| Graber, Virgil R. | Elkhart | Elkhart |
| Graessle, Harold P. (S) | Seymour | Jackson-Jennings |
| Graf, Jerome A. | Bloomfield | Greene |
| Graf, John P. | South Bend | St. Joseph |
| Graham, Edward W. | Indianapolis | Marion |
| Graham, George M. | Fort Wayne | Allen |
| Graham, James C. | Fort Wayne | Allen |
| Graham, John D. | Indianapolis | Marion |
| Graham, William E. | Indianapolis | Marion |
| Grangier, Bernard A. | Columbus | Bartholomew-Brown |
| Grant, Benjamin F. | Gary | Lake |
| Grant, M. Arthur | Marion | Grant |
| Grant, Phyllis A. | New Castle | Henry |
| Graves, Noel S. | Vevay | Jefferson-Switzerland |
| Graves, Orville M. (S) | Princeton | Gibson |
| Gray, Daniel E. | Crown Point | Lake |
| Gray, Edwin H. | Elkhart | Elkhart |
| Gray, Kenneth L. | Indianapolis | Marion |
| Gray, Leon | Martinsville | Morgan |
| Gray, Mary Case | Elkhart | Elkhart |
| Grayson, Merrill | Indianapolis | Marion |
| Grayson, Ted L. | Indianapolis | Marion |
| Grayston, Wallace S. (S) | Huntington | Huntington |
| Green, Frank H., Jr. | Rushville | Rush |
| Green, G. Richard | South Bend | St. Joseph |
| Green, George F. | South Bend | St. Joseph |
| Green, Joseph B. | Indianapolis | Marion |
| Green, Leonard J. | Valparaiso | Porter |
| Green, Morris | Indianapolis | Marion |
| Green, Norval E. | South Bend | St. Joseph |
| Green, Robert F. | Fort Wayne | Allen |
| Green, William L. | Shelbyville | Shelby |
| Greenburg, Louis T. | Evansville | Vanderburgh |
| Greene, Frederick G. (S) | Seelyville | Parke-Vermillion |
| Greene, Morgan E. | Indianapolis | Marion |
| Greene, Robert W. | Rensselaer | Jasper |
| Greene, William R. | Henryville | Clark |
| Greenlee, Joseph A., Jr. | Avilla | Noble |
| Greenlee, Robert L. | Fort Wayne | Allen |
| Gregg, Albert F. | Connersville | Fayette-Franklin |
| Gregg, Edwin E. | Thorntown | Boone |
| Gregoline, Amadeo F. | Gary | Lake |

| Name | City | County |
|---|---|---|
| Gregoline, Eugene | Gary | Lake |
| Gregory, Robert L. | Indianapolis | Marion |
| Greiber, Marvin F. | Muncie | Delaware-Blackford |
| Greisen, Jack G. | Whiting | Lake |
| Greist, John H. | Indianapolis | Marion |
| Gresham, Edwin L. | Aurora | Dearborn-Ohio |
| Griep, Arthur H. | Evansville | Vanderburgh |
| Griest, Walter D. | Fort Wayne | Allen |
| Griffin, Charles G. | Valparaiso | Porter |
| Griffin, Joseph P. | Chesterton | Porter |
| Griffin, Leslie W. | Indianapolis | Marion |
| Griffith, Harold R. | Fort Wayne | Allen |
| Griffith, James W. | Sheridan | Hamilton |
| Griffith, Richard S. | Indianapolis | Marion |
| Griffith, Ross E. | Indianapolis | Marion |
| Griffith, Thomas E. | Munster | Lake |
| Grigsby, Hardin B. | Lebanon | Boone |
| Grillo, Donald | South Bend | St. Joseph |
| Grimes, Hubert N. | Indianapolis | Marion |
| Grimm, William C. H., Jr. | Evansville | Vanderburgh |
| Gripe, Richard P. | Lafayette | Tippecanoe |
| Grisell, Ted L. | Indianapolis | Marion |
| Grorud, Alton C. | South Bend | St. Joseph |
| Grosso, William G. | East Chicago | Lake |
| Grosz, Hanus J. | Indianapolis | Marion |
| Grothouse, Carl B. | Kokomo | Howard |
| Grove, James H. | South Bend | St. Joseph |
| Gruber, Charles M. | Indianapolis | Marion |
| Guckien, Joseph L. | Evansville | Vanderburgh |
| Guild, John K. | Plymouth | Marshall |
| Guin, Jere D. | Kokomo | Howard |
| Gumbert, Jack L. | Indianapolis | Marion |
| Gunderson, Shaun D. | Goshen | Elkhart |
| Gustafson, Milton H. | Muncie | Delaware-Blackford |
| Gustaitis, John W. | Whiting | Lake |
| Guthrie, James R. | Richmond | Wayne-Union |
| Guthrie, James U. | Peru | Miami |
| Guthrie, William H. | Butlerville | Jackson-Jennings |
| Gutierrez, Peter E. | Crown Point | Lake |
| Gutstein, Richard R. (S) | Kendallville | Noble |
| Guttman, John B. | Wakarusa | Elkhart |
| Guzman, Marcelino F. | Morocco | Newton |

## H

| Name | City | County |
|---|---|---|
| Haas, Charles F. | Lafayette | Tippecanoe |
| Habegger, Elmer D. | Indianapolis | Marion |
| Hackett, Walter G. | Fort Wayne | Allen |
| Hackney, Victor C. | Indianapolis | Marion |
| Hadey, James H. | Gary | Lake |
| Hadley, David | Indianapolis | Marion |
| Haffner, Herman G. | Fort Wayne | Allen |
| Hagan, Marion L. | French Lick | Orange |
| Haggard, David B. | Plainfield | Hendricks |
| Haggard, Edmund B. | Indianapolis | Marion |
| Hagie, Franklin E. | Richmond | Wayne-Union |
| Hagman, Norman A. | Ft. Leonard Wood, Mo. | Marion |
| Haith, John W. | Gary | Lake |
| Hales, Robert E. | Roachdale | Montgomery |
| Haley, Alvin J. | Fort Wayne | Allen |
| Haley, George M. | South Bend | St. Joseph |
| Haley, Paul E. | South Bend | St. Joseph |
| Halfast, Richard W. | Kokomo | Howard |
| Hall, Bernard R. | Logansport | Cass |
| Hall, Donald L. | Petersburg | Pike |
| Hall, Frank M. | Indianapolis | Marion |
| Hall, Jack H. | Indianapolis | Marion |
| Hall, James M. | South Bend | St. Joseph |
| Hall, Robert S. | Muncie | Delaware-Blackford |
| Hall, Thomas C. | Chesterton | Porter |
| Hall, William R. | Fort Wayne | Allen |
| Halleck, Harold J. | Winamac | Pulaski |
| Haller, Carol A. | Milwaukee, Wisc. | Marion |
| Haller, Richard C. | Fort Wayne | Allen |
| Haller, Robert L. | Kempton | Tipton |
| Haller, Thomas C. | Crawfordsville | Montgomery |
| Halley, Robert | Gary | Lake |
| Hamer, Homer G. (S) | Indianapolis | Marion |
| Hamilton, Antha A. | Vevay | Jefferson-Switzerland |
| Hamilton, Charles O. | South Bend | St. Joseph |
| Hamilton, Emory D. | Fort Wayne | Allen |
| Hamilton, George M. | Fort Wayne | Allen |
| Hamilton, Howard B. | Indianapolis | Marion |
| Hamilton, James R. | Mitchell | Lawrence |
| Hamilton, M. Luther (S) | Newberry | Greene |
| Hamilton, Orville G. (S) | Bluffton | Wells |
| Hamilton, Thomas | Columbia City | Whitley |
| Hammel, Howard T. | Bedford | Lawrence |
| Hammer, Jay W. | Indianapolis | Madison |
| Hammersley, George K. | Frankfort | Clinton |
| Hammond, R. Case | Evansville | Vanderburgh |
| Hammond, Stanley | Munster | Lake |
| Hampshire, Donald R. | Indianapolis | Marion |
| Hampton, James N. | Argos | Marshall |
| Han, Daniel | Gary | Lake |
| Hance, Darwood B. | Richmond | Wayne-Union |
| Hance, Joseph W. | Fort Wayne | Allen |
| Hancock, John G. | Indianapolis | Marion |
| Haney, William K. | Madison | Jefferson-Switzerland |
| Hanley, Harriet F. | South Bend | St. Joseph |
| Hann, Eldon C. | Indianapolis | Marion |
| Hanna, Thomas A. | Indianapolis | Marion |
| Hannah, Jack W. | Elkhart | Elkhart |
| Hanneken, Vincent J. | Wabash | Wabash |
| Hannemann, Robert E. | Lafayette | Tippecanoe |
| Hansell, Robert M. | Indianapolis | Marion |
| Hanson, Martin F. | Elwood | Madison |
| Harcourt, Allan K. | Indianapolis | Marion |
| Harcourt, Robert S. | Indianapolis | Marion |
| Harden, Murray E. | Lafayette | Tippecanoe |
| Hardin, Wayne E. | Ossian | Wells |
| Harding, M. Richard | Indianapolis | Marion |
| Harding, Myron S. | Indianapolis | Marion |
| Hardtke, Eldred F. | Bloomington | Owen-Monroe |
| Hardy, John J. (S) | North Liberty | St. Joseph |
| Hare, Daniel M. | Evansville | Vanderburgh |
| Hare, Earl H. (S) | Indianapolis | Marion |
| Hare, Francis W., Jr. | Madison | Jefferson-Switzerland |
| Hare, Laura | Indianapolis | Marion |
| Harger, Robert W. | Indianapolis | Marion |
| Hargett, Herbert P. | Jeffersonville | Clark |
| Harkness, Robert G. | Terre Haute | Vigo |
| Harlan, William L. | Evansville | Vanderburgh |
| Harless, O. Fred | Monroeville | Allen |
| Harmon, Carl J. | Richmond | Wayne-Union |
| Harned, Ben K., Jr. | Evansville | Vanderburgh |
| Harper, James W. | East Chicago | Lake |
| Harrington, James F. | Logansport | Cass |
| Harris, Carl B. | Indianapolis | Marion |
| Harris, George F. | Madison | Jefferson-Switzerland |
| Harris, James C. | Indianapolis | Marion |
| Harris, Leo C. | New Albany | Floyd |
| Harris, Neil R. | Goshen | Elkhart |
| Harris, Paul N. | Greenfield | Marion |
| Harris, Robert F. | Noblesville | Hamilton |
| Harris, Robert L. | Evansville | Vanderburgh |
| Harrison, Benjamin L. | New Castle | Henry |
| Harshman, James A. | Kokomo | Howard |
| Harshman, Louis P. (S) | Frankfort | Allen |
| Harstad, Casper | Rockville | Parke-Vermillion |
| Hart, L. Paul | Evansville | Vanderburgh |

| Name | City | County |
|---|---|---|
| Hart, Robert B. | Columbus | Bartholomew-Brown |
| Harter, Eli B. | Lafayette | Tippecanoe |
| Hartley, Clarence A., Jr. | Evansville | Vanderburgh |
| Hartman, John J. | Angola | Steuben |
| Hartsough, Ralph I. | Lakeville | St. Joseph |
| Hartz, F. Minton | Evansville | Vanderburgh |
| Harvey, Bennett B. | Lafayette | Tippecanoe |
| Harvey, David M. | Munster | Lake |
| Harvey, Emerson C., Jr. | Muncie | Delaware-Blackford |
| Harvey, Harry C. (S) | Franklin | Allen |
| Harvey, John C. | Auburn | DeKalb |
| Harvey, Ralph J. (S) | Zionsville | Boone |
| Harvey, Verne K., Jr. | Indianapolis | Marion |
| Harvey, Verne K., Sr. | Zionsville | Marion |
| Hasewinkel, Carroll W. | Carmel | Marion |
| Hasewinkle, August M. | Fort Wayne | Allen |
| Hash, John S. | Noblesville | Hamilton |
| Hashemi, Hossein | Warsaw | Kosciusko |
| Haslem, Ezra R. | Terre Haute | Vigo |
| Haslem, John R. | Terre Haute | Vigo |
| Hass, Caroline E. | W. Lafayette | Tippecanoe |
| Hass, Thomas W. | W. Lafayette | Tippecanoe |
| Hassel, Walter B. | Evansville | Vanderburgh |
| Hastings, Warren C. | Fort Wayne | Allen |
| Hatfield, Jack J. | Indianapolis | Marion |
| Hatfield, Nicholas W. | Indianapolis | Marion |
| Hathaway, C. Bishop | Auburn | DeKalb |
| Hattendorf, Anton P. | Fort Wayne | Allen |
| Hauersperger, Alfred D. | Columbus | Bartholomew-Brown |
| Haugseth, Ellsworth K. | South Bend | St. Joseph |
| Havens, A. Lyle | Jeffersonville | Clark |
| Havens, Thomas R. | Jeffersonville | Clark |
| Havens, Oscar | Cicero | Hamilton |
| Havens, Russell E. | Fort Wayne | Allen |
| Hawes, Marvin E. | Columbus | Bartholomew-Brown |
| Hawk, James H. | Indianapolis | Marion |
| Hawkins, Glen E. | South Bend | St. Joseph |
| Hawkins, Richard D. | Bedford | Lawrence |
| Hay, Gene R. | Michigan City | La Porte |
| Hayes, Frank W. | San Francisco, Calif. | Lake |
| Hayes, Jesse D. | East Chicago | Lake |
| Hayes, Theodore R. | Muncie | Delaware-Blackford |
| Haymond, George M. | Warsaw | Kosciusko |
| Haymond, Joseph L. | Indianapolis | Marion |
| Haynes, John T. | Indianapolis | Marion |
| Hays, Everett L. (S) | Indianapolis | Marion |
| Haywood, John G. | Noblesville | Hamilton |
| Headley, Lloyd M. | Lebanon | Boone |
| Healey, Robert J. | Indianapolis | Marion |
| Heard, Albert | Evansville | Vanderburgh |
| Heck, Martin C. | Jasper | Dubois |
| Hedde, Eugene L. | Logansport | Cass |
| Hedgcock, Robert A. | Frankfort | Clinton |
| Hedrick, James T. | Gary | Lake |
| Hedrick, Philip W. | Indianapolis | Marion |
| Hehemann, William V. | Munster | Lake |
| Heid, George J., Jr. | Lafayette | Tippecanoe |
| Heilman, William C., Jr. | New Castle | Henry |
| Heilman ,W. C., Sr. (S) | New Castle | Henry |
| Heimburger, Robert F. | Indianapolis | Marion |
| Heinlein, Carl L. | Danville | Hendricks |
| Heinrich, Weston A. | Evansville | Vanderburgh |
| Held, George A. | Jasper | Dubois |
| Helmen, Charles H. | Indianapolis | Marion |
| Helmen, Harry W. (S) | Rolling Prairie | St. Joseph |
| Helmer, Frederic A. | Cincinnati, Ohio | Allen |
| Helmer, John F. | South Bend | St. Joseph |
| Heminway, Norman L. | Elkhart | Elkhart |
| Hendershot, Eugene L. | Evansville | Vanderburgh |
| Henderson, Francis G. | Indianapolis | Marion |
| Henderson, Norman C. | Michigan City | La Porte |
| Henderson, Ramon A. | Muncie | Delaware-Blackford |
| Henderson, Roscoe C. | Indianapolis | Marion |
| Henderson, William P. | Indianapolis | Marion |
| Hendricks, Fred A. | Indianapolis | Marion |
| Hendricks, John W. | Indianapolis | Marion |
| Hendrix, Charles E. | Vincennes | Knox |
| Henn, R. Anthony | Greenfield | Hancock |
| Henry, Alvin L. | Columbus | Bartholomew-Brown |
| Henry, Howard J. | Knox | Starke |
| Henry, Russell S. | Indianapolis | Marion |
| Hepburn, C. K. | Indianapolis | Marion |
| Hepner, Herman | Kendallville | Noble |
| Hepner, Herman S. | Bloomington | Owen-Monroe |
| Herd, Cloyn R. | Peru | Miami |
| Herendeen, Elbie V. | Rochester | Fulton |
| Heritier, C. Jules | Columbia City | Whitley |
| Hermayer, Stephen | Evansville | Vanderburgh |
| Hernandez, Antonio | Shelburn | Sullivan |
| Hernandez, I. C. | East Chicago | Lake |
| Herr, John W. (S) | Tell City | Perry |
| Herrick, Charles L. | Akron | Fulton |
| Herrmann, Gordon T. | Evansville | Vanderburgh |
| Herrold, George W. | Lafayette | Tippecanoe |
| Hershberger, Philip G. | Fort Wayne | Allen |
| Hershey, Ernest A. (S) | Churubusco | Whitley |
| Herzberg, Milton | Clinton | Parke-Vermillion |
| Herzer, Clarence C. | Evansville | Vanderburgh |
| Hess, Paul P. | New Albany | Floyd |
| Hetherington, John A. | Indianapolis | Marion |
| Hetman, Mitchell J. | Westville | La Porte |
| Heubi, John E. | Indianapolis | Marion |
| Hewlett, George R. | Gary | Lake |
| Hibbs, William G. | Franklin | Johnson |
| Hibner, Dan W. | Indianapolis | Marion |
| Hibner, Nolan A. | Monticello | White |
| Hibner, Kermit Q. | Bloomington | Owen-Monroe |
| Hickam, John B. | Indianapolis | Marion |
| Hickman, Donald M. | Fort Wayne | Allen |
| Hickman, Jack W. | Indianapolis | Marion |
| Hickman, Walter F. (S) | Indianapolis | Marion |
| Hicks, Murwyn L. | Indianapolis | Marion |
| Hicks, Wilbur P. | Indianapolis | Marion |
| Higgins, James L. | APO, 83, New York, N. Y. | Pike |
| Higgins, John R. | New Albany | Floyd |
| High, Ralph L. | Muncie | Delaware-Blackford |
| Hilbert, John W. (S) | South Bend | St. Joseph |
| Hildebrand, John O., Jr. | South Bend | St. Joseph |
| Hildebrand, William L. | Indianapolis | Marion |
| Hill, Gladys Marie | Richmond | Wayne-Union |
| Hill, Herbert N. | Indianapolis | Marion |
| Hill, James K. | Indianapolis | Marion |
| Hill, Kenneth G. | New Castle | Henry |
| Hill, Lloyd L. | Peru | Miami |
| Hill, Paul G. | Cambridge City | Wayne-Union |
| Hill, Robert E. | Yorktown | Delaware-Blackford |
| Hill, Theodore A. | South Bend | St. Joseph |
| Hill, Wallace C. | South Bend | St. Joseph |
| Hillenbrand, Charles | Michigan City | La Porte |
| Hillery, Robert L. | Fort Wayne | Allen |
| Hillis, Lowell J. | Logansport | Cass |
| Hillman, Marion W. | Westville | St. Joseph |
| Hilz, James M. | Indianapolis | Marion |
| Himebaugh, Gilbert J. | Evansville | Vanderburgh |
| Himler, James M. | Indianapolis | Marion |
| Hinchman, Jean F. | Parker | Delaware-Blackford |
| Hines, Archie V. (S) | Auburn | De Kalb |
| Hines, Don C. | Indianapolis | Marion |
| Hines, John H. | Auburn | De Kalb |

| Name | County | City |
|---|---|---|
| Hippensteel, Harland | Auburn | De Kalb |
| Hippensteel, Russell R. | Culver | Marshall |
| Hipskind, Richard E. | Fort Wayne | Allen |
| Hirsch, Herman L. | Mt. Vernon | Posey |
| Hisrich, Lloyd W. | Batesville | Ripley |
| Hobbs, Arthur A. | Evansville | Vanderburgh |
| Hobgood, James L., Jr. | Evansville | Vanderburgh |
| Hochhalter, Marian | Logansport | Cass |
| Hodgin, Phillip T. | Orleans | Orange |
| Hodurski, Zigfield | Gary | Lake |
| Hoetzer, Eldore M. | New Haven | Allen |
| Hoffman, Arthur F. | Fort Wayne | Allen |
| Hoffman, Doris | Vincennes | Knox |
| Hoffman, Herman | Indianapolis | Marion |
| Hoffman, Max N. | Covington | Fountain-Warren |
| Hofmann, J. William (S) | Indianapolis | Marion |
| Hogan, Michael A. | Indianapolis | Marion |
| Hogan, Thomas W. | Terre Haute | Vigo |
| Hogle, Frank D. | Warsaw | Kosciusko |
| Hoham, Frederick D. | Portage | Lake |
| Hoit, Leonard | Gary | Lake |
| Holdeman, Lillian S. | South Bend | St. Joseph |
| Holdeman, Richard W. | South Bend | St. Joseph |
| Holden, Gary R. | New Market | Montgomery |
| Holladay, Lloyd J. | Lafayette | Tippecanoe |
| Holland, Deward J. (S) | Bloomington | Owen-Monroe |
| Holland, William M. | Indianapolis | Marion |
| Holland, Philip T. | Bloomington | Owen-Monroe |
| Hollenberg, Alfred E. | Hagerstown | Henry |
| Hollenberg, Edward L. | Winamac | Pulaski |
| Holliday, Alfonso | Gary | Lake |
| Holm, Leo H. | Indianapolis | Marion |
| Holman, Jerome E., Jr. | Indianapolis | Marion |
| Holman, Jerome E., Sr. (S) | Indianapolis | Marion |
| Holmes, Claude D. (S) | Coral Gables, Fla. | Clinton |
| Holmes, George H., Jr. | Indianapolis | Marion |
| Holmes, John L. | Muncie | Delaware-Blackford |
| Holsinger, Robert E. | Fort Wayne | Allen |
| Holtzman, Norman N. | South Bend | St. Joseph |
| Holtzman, Paul W. | Bloomington | Owen-Monroe |
| Honan, Paul R. | Lebanon | Boone |
| Hood, Ainslee A. | Indianapolis | Marion |
| Hooker, Donald J. | Ligonier | Noble |
| Hoopes, Jane M. | Evansville | Vanderburgh |
| Hoover, Dewey A. | Terre Haute | Vigo |
| Hoover, J. Guy | Evansville | Vanderburgh |
| Hoover, Joseph R. | Fort Wayne | Allen |
| Hoover, Peter B. | Boonville | Warrick |
| Hopkins, Bruce J. | Indianapolis | Marion |
| Hopkins, Joseph R. | Hammond | Lake |
| Hopkins, L. H. | Versailles | Ripley |
| Hoppenrath, William H. (S) | Elwood | Madison |
| Horlander, Fridolin | Henryville | Clark |
| Horning, Richard R. | Logansport | Cass |
| Horst, William N. | Crown Point | Lake |
| Horswell, Richard G. | Bristol | Elkhart |
| Horswell, Richard R. | Lafayette | Tippecanoe |
| Horwitz, Thomas | Indianapolis | Marion |
| Hoskins, Phillip A. | Ann Arbor, Mich. | Lake |
| Hostetler, Carl M. | Goshen | Elkhart |
| Hostetter, Irwin S. | Muncie | Delaware-Blackford |
| Houser, D. Stanley | South Bend | St. Joseph |
| Houshmand, Cyrus | Bloomington | Owen-Monroe |
| Houston, Fred D. | Lawrenceburg | Dearborn-Ohio |
| Hovda, Richard B. | Evansville | Vanderburgh |
| Hover, Galen M. | Marion | Grant |
| How, Louis E. | South Bend | St. Joseph |
| Howard, Joseph D. | Culver | Marshall |
| Howard, Wm. Harry | Hammond | Lake |

| Name | City | County |
|---|---|---|
| Howe, Fordyce L. | Fort Wayne | Allen |
| Howell, Arthur | Indianapolis | Marion |
| Howell, Joseph D. | Indianapolis | Marion |
| Hoyt, John M. | Kokomo | Howard |
| Hoyt, Lester H. | Indianapolis | Marion |
| Hoyt, Millard L. | Indianapolis | Marion |
| Hrisomalos, Frank N. | Bloomington | Owen-Monroe |
| Hubbard, Jesse D. | Indianapolis | Marion |
| Huber, Carl P. | Indianapolis | Marion |
| Huckleberry, Irvin E. | Salem | Washington |
| Hudson, Arlington M. | Connersville | Fayette-Franklin |
| Hudson, Foster J. (S) | Indianapolis | Marion |
| Huffman, Galen C. | Bluffton | Wells |
| Huffman, Verlin P. | S. Whitley | Whitley |
| Hughes, Anson F. | Lafayette | Tippecanoe |
| Hughes, Richard R. | Lafayette | Tippecanoe |
| Hughes, William B. | Waterloo | DeKalb |
| Huggins, Victor S. | Evansville | Vanderburgh |
| Hull, De Wayne L. | San Antonio, Texas | Marion |
| Hull, James E. | Lafayette | Tippecanoe |
| Hull, Ronald H. | Indianapolis | Marion |
| Hummel, Russel M. | Marion | Grant |
| Hummons, Francis D. | Indianapolis | Marion |
| Humphrey, Edward M. | Covington | Fountain-Warren |
| Humphrey, Paul E. | Terre Haute | Vigo |
| Humphreys, Joe E. | Vincennes | Knox |
| Humphreys, John L. | Fort Wayne | Allen |
| Humphreys, John W. | Crawfordsville | Montgomery |
| Hunsberger, Walter G. | Lafayette | Tippecanoe |
| Hunt, Edgar J. | Terre Haute | Vigo |
| Hunt, Gayle J. | Richmond | Wayne-Union |
| Hunt, H. Richard | Indianapolis | Marion |
| Hunter, Donn R. | Greenfield | Hancock |
| Hunter, Frank P. (S) | Lafayette | Tippecanoe |
| Hunter, Lowell G. | Lawrenceburg | Dearborn-Ohio |
| Huoni, John S. | Jeffersonville | Clark |
| Hurley, James W. | Elkhart | Elkhart |
| Hurley, John R. | Daleville | Delaware-Blackford |
| Hurt, LaVerne B. | Delray Beach, Fla. | Marion |
| Hurteau, William W. | Indianapolis | Marion |
| Huse, William M. | Indianapolis | Marion |
| Husted, Robert G. | Munster | Lake |
| Hutchison, Donald R. | Fountain City | Wayne-Union |
| Hutto, William H. | Kokomo | Howard |
| Hyatt, Gilbert T. | Evansville | Vanderburgh |
| Hyde, Carroll C. (S) | South Bend | St. Joseph |

## I

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|---|---|---|
| Imhof, Joseph D. | Muncie | Delaware-Blackford |
| Ingram, Richard | Montpelier | Delaware-Blackford |
| Ingwell, Guy B. | Knox | Starke |
| Inlow, Herbert H. | Shelbyville | Shelby |
| Inlow, Paul M. | Shelbyville | Shelby |
| Inlow, Robert P. | Shelbyville | Shelby |
| Inlow, William D. (S) | Shelbyville | Shelby |
| Irish, Wilbur J. | East Chicago | Lake |
| Irmscher, George W. | Fort Wayne | Allen |
| Irmscher, Jane M. | Fort Wayne | Allen |
| Irvine, William O. | Indianapolis | Marion |
| Irwin, Glenn W., Jr. | Indianapolis | Marion |
| Isenogle, Kenneth F. | Fort Wayne | Allen |
| Iske, Paul G. | Indianapolis | Marion |
| Isler, Nathaniel C. | Jeffersonville | Clark |
| Iterman, George E. (S) | New Castle | Henry |
| Ivy, John H. | Elkhart | Elkhart |

## J

| | | |
|---|---|---|
| Jackson, Charles E. | Bluffton | Wells |

| Name | City | County |
|---|---|---|
| Jackson, Dean B. | Hartford City | Delaware-Blackford |
| Jackson, Howard C. | Madison | Jefferson-Switzerland |
| Jackson, James W. (S) | Indianapolis | Marion |
| Jackson, John F. | Fort Wayne | Allen |
| Jackson, John K. | Aurora | Dearborn-Ohio |
| Jacobo, Miguel J. | East Chicago | Lake |
| Jacobs, E. Robert | Indianapolis | Bartholomew-Brown |
| Jacqmain, Ralph J. | Vincennes | Marion |
| Jaeger, Alfred S. (S) | Indianapolis | Marion |
| Jahns, Albin A. | Gary | Lake |
| James, Charles E. | Indianapolis | Marion |
| James, Nicholas A. (S) | Tell City | Perry |
| James, Thomas, Jr. | Huntington | Huntington |
| Jankowski, Ernest B. | South Bend | St. Joseph |
| Jaquith, Orville S. (S) | Indianapolis | Marion |
| Jarrett, John C. | Marion | Grant |
| Jarrett, Paul E. | Anderson | Madison |
| Jay, Arthur N. | Indianapolis | Marion |
| Jay, James M. | Indianapolis | Marion |
| Jehanyar, M. Ali | Monticello | White |
| Jenkins, Robert E. | Indianapolis | Marion |
| Jennings, Frank L. (S) | Indianapolis | Marion |
| Jett, Clyde W. | Seelyville | Vigo |
| Jewell, George M. | Kokomo | Howard |
| Jewett, Joe H. | Indianapolis | Marion |
| Jinnings, Loren E. | Garrett | De Kalb |
| Jobes, James E. | Indianapolis | Marion |
| Johns, David R. (S) | East Chicago | Lake |
| Johns, Nicholas C. | South Bend | St. Joseph |
| Johnson, Arnold L. | Gary | Lake |
| Johnson, Earl H. | Indianapolis | Marion |
| Johnson, Edward M. | Terre Haute | Vigo |
| Johnson, George M. | Richmond | Wayne-Union |
| Johnson, Herbert S. | Lafayette | Tippecanoe |
| Johnson, James B. | Greencastle | Putnam |
| Johnson, Jerome M. | Jeffersonville | Clark |
| Johnson, Lonnie B. (S) | Gary | Lake |
| Johnson, Lowell R. | Lafayette | Tippecanoe |
| Johnson, Paul D., Jr. | Terre Haute | Vigo |
| Johnson, Robert D. | Madison | Jefferson-Switzerland |
| Johnson, Stephen L. | Evansville | Vanderburgh |
| Johnson, Thomas A. | Indianapolis | Marion |
| Johnson, Victor | Evansville | Vanderburgh |
| Johnson, William A. | North Vernon | Jackson-Jennings |
| Johnson, William H. | Gary | Lake |
| Johnston, Donald D. (S) | Thousand Oaks, Calif. | La Porte |
| Johnston, Richard M. | Fort Wayne | Allen |
| Johnston, Robert G. (S) | Huntington | Huntington |
| Jolly, Lewis E. | Madison | Jefferson-Switzerland |
| Jolly, Wesley P. (S) | Richland | Spencer |
| Jones, Albert T. | Anderson | Madison |
| Jones, Allen W. | Indianapolis | Marion |
| Jones, Charles A. | Franklin | Johnson |
| Jones, David E. | Indianapolis | Marion |
| Jones, David G. | Anderson | Madison |
| Jones, David H. | Charlestown | Clark |
| Jones, David M. | Lafayette | Tippecanoe |
| Jones, Edwin F. | Rensselaer | Jasper |
| Jones, Eli S. | Hammond | Lake |
| Jones, Francis P. | Indianapolis | Marion |
| Jones, George L. | Indianapolis | Marion |
| Jones, Gordon C. | Indianapolis | Marion |
| Jones, Harold N. | Gary | Lake |
| Jones, Horace E. | Anderson | Madison |
| Jones, J. Carl | Logansport | Cass |
| Jones, King S. | Michigan City | La Porte |
| Jones, Lawrence R. | Greencastle | Putnam |
| Jontz, Joe G. | Fort Wayne | Allen |
| Jontz, Jon P. | Indianapolis | Marion |
| Jontz, Richard L. | Fort Wayne | Allen |
| Jordan, Leo E. | Lynn | Randolph |
| Jordan, Richard A. | Corydon | Harrison-Crawford |
| Joseph, Rex M. | Indianapolis | Marion |
| Jowitt, Richard H. | Indianapolis | Marion |
| Judd, Donald R. | Muncie | Delaware-Blackford |
| Judd, Russell L. | Indianapolis | Marion |
| Judson, Walter E. | Indianapolis | Marion |
| Juergens, Richard B. | Fort Wayne | Allen |
| Jurgensen, Walter T. | Fort Wayne | Allen |
| Justin, Renate G. | Terre Haute | Vigo |

## K

| | | |
|---|---|---|
| Kabel, Robert N. | Terre Haute | Vigo |
| Kahler, Maurice V. (S) | Indianapolis | Marion |
| Kahn, Alexander J. | Indianapolis | Marion |
| Kahn, Howard L. | Indianapolis | Marion |
| Kaiser, James L. | Indianapolis | Marion |
| Kalker, Morton | Muncie | Delaware-Blackford |
| Kalsbeck, John E. | Indianapolis | Marion |
| Kaltenthaler, Albert | Gary | Lake |
| Kamen, Jack M. | Gary | Lake |
| Kamm, Bernard A. | South Bend | St. Joseph |
| Kammen, Leo | Indianapolis | Marion |
| Kammen, Robert | Fresno, Calif. | Marion |
| Kammer, Grace C. | Muncie | Delaware-Blackford |
| Kammer, Walter F. | Muncie | Delaware-Blackford |
| Kantzer, Floyd B. | Garrett | De Kalb |
| Karberg, Richard J. | Lafayette | Tippecanoe |
| Karlick, Joseph R. | Arcadia | Hamilton |
| Karn, John W. | South Bend | St. Joseph |
| Karnafel, Eugene T. | Madison | Jefferson-Switzerland |
| Karol, Herbert J. | Fort Wayne | Allen |
| Karpel, Bernard | Mooresville | Hendricks |
| Karsell, William A. | Indianapolis | Marion |
| Kasting, Gerald | Bedford | Lawrence |
| Katterjohn, James C. | Indianapolis | Marion |
| Kauffman, Harley M. | Evansville | Vanderburgh |
| Kauffman, Nelson N. | Indianapolis | Marion |
| Kaufman, Julian R. | Fort Wayne | Allen |
| Kay, Oran E. | Spencer | Owen-Monroe |
| Keating, John U. | Elkhart | Elkhart |
| Kebel, Arthur P. | Indianapolis | Marion |
| Keck, Carleton A. | Fort Wayne | Allen |
| Keeling, Forrest E. | Portland | Jay |
| Keenan, George B. | Indianapolis | Marion |
| Keever, Charles H. | Indianapolis | Marion |
| Keiser, Venice D. (S) | Indianapolis | Marion |
| Kellar, Philip E. | Hobart | Lake |
| Kelly, Don E. | Indianapolis | Marion |
| Kelly, Francis J. | Whiting | Lake |
| Kelly, Frank (S) | Argos | Marshall |
| Kelly, John B. | Evansville | Vanderburgh |
| Kelly, Wendell C. | Anderson | Madison |
| Kelsey, Lawrence E. | Phoenix, Ariz. | Fulton |
| Kelsey, Robert M., Jr. | La Porte | La Porte |
| Kelsey, Robert M., Sr. | Costa Mesa, Calif. | La Porte |
| Kemp, John T. | Michigan City | La Porte |
| Kemp, W. Alfred | Bourbon | Marshall |
| Kempf, Gerald F. (S) | Rockville | Parke-Vermillion |
| Kendall, Forest M. | Nappanee | Elkhart |
| Kendall, William R. | Richmond | Wayne-Union |
| Kendrick, Frank J. | Gary | Lake |
| Kendrick, William M. | Mooresville | Morgan |
| Kennedy, Hunter F. | Indianapolis | Marion |
| Kennedy, Joseph T. | Indianapolis | Marion |
| Kennedy, Myron S. | Goshen | Elkhart |
| Kennedy, Walter U. (S) | New Castle | Henry |
| Kenney, David B. | Indianapolis | Marion |
| Kenney, Francis D. | Hammond | Lake |

| Name | City | County |
|---|---|---|
| Kenoyer, Wilbur L. | New York, N. Y. | Marion |
| Kent, Richard N. | Fort Wayne | Allen |
| Kenyon, C. Emil | Cambridge City | Wayne-Union |
| Kenzler, Jack I. | Indianapolis | Marion |
| Keough, Thomas F. | Warsaw | Kosciusko |
| Kephart, S. Bruce | Bluffton | Wells |
| Kepler, Robert W. | La Porte | La Porte |
| Keplinger, James E. | W. Lafayette | Tippecanoe |
| Kepner, Robert S. | Chesterfield | Madison |
| Kercheval, John M. | Clinton | Parke-Vermillion |
| Kern, Clarence G. | Lebanon | Boone |
| Kerr, Charlotte H. | Michigan City | La Porte |
| Kerr, Donald M. | Bedford | Lawrence |
| Kerr, Harry R. | Indianapolis | Marion |
| Kerr, John E. | Michigan City | La Porte |
| Kerrigan, John F. | Michigan City | La Porte |
| Kerrigan, Robert L. (S) | Michigan City | La Porte |
| Kerrigan, William F. | Connersville | Fayette-Franklin |
| Keseric, N. E. | French Lick | Orange |
| Kesim, Mufit H. | Elkhart | Elkhart |
| Kessler, Robert B. | Evansville | Vanderburgh |
| Ketcham, Jane M. (S) | Indianapolis | Marion |
| Ketcham, John S. (S) | Rossville | Clinton |
| Keyes, Robert C. | Fort Wayne | Allen |
| Khaton, Odessa M. | Gary | Lake |
| Kidd, James G. (S) | Jefferson, Wis. | Wabash |
| Kidder, Orva T. | Fort Wayne | Allen |
| Kiechle, Frederich L. | Evansville | Vanderburgh |
| Kieffer, William J. | South Bend | St. Joseph |
| Kielton, Melvyn J. | Elkhart | Elkhart |
| Kiely, John T. | Anderson | Madison |
| Kilgore, Byron W. | Ft. Wayne | Allen |
| Kilmer, Warren L. | Portage | Porter |
| Kim, Joon S. | Muncie | Delaware-Blackford |
| Kim, Young D. | Beech Grove | Marion |
| Kimbrough, Robert F. | Fort Wayne | Allen |
| Kime, Charles E. | Richmond | Wayne-Union |
| Kime, Edwin N. (S) | Bloomington | Marion |
| Kimmel, George E. | Evansville | Vanderburgh |
| Kincaid, Raymond K. | Tipton | Tipton |
| Kincaid, Robert S. | Evansville | Vanderburgh |
| Kindell, Hurschell D. | New Richmond | Montgomery |
| King, Harold | Indianapolis | Marion |
| King, Jay M. | Logansport | Cass |
| King, Joseph W. | Anderson | Madison |
| King, Robert W. | Cedar Lake | Lake |
| Kingsbury, John K. (S) | Indianapolis | Marion |
| Kinneman, Robert E. | Greenfield | Hancock |
| Kintner, Burton E. | Elkhart | Elkhart |
| Kinzer, LeRoy D. | Markle | Huntington |
| Kirby, Ted C. | Greenfield | Hancock |
| Kirkhoff, Paul J. | Indianapolis | Marion |
| Kirklin, Oren L. | Indianapolis | Marion |
| Kirshman, Forrest E. | Muncie | Delaware-Blackford |
| Kirtley, James M. | Crawfordsville | Montgomery |
| Kirtley, Robert W. | Danville | Hendricks |
| Kirtley, William R. | Indianapolis | Marion |
| Kissel, Wesley A. | Indianapolis | Marion |
| Kissinger, Knight L. | Angola | Steuben |
| Kistler, James J. | La Porte | La Porte |
| Kistner, Arthur W. | Elkhart | Elkhart |
| Kitterman, Harry E. | Indianapolis | Marion |
| Klain, Benjamin V. | Indianapolis | Marion |
| Klamer, Charles H. | Jasper | Dubois |
| Klassen, Otto D. | Elkhart | Elkhart |
| Klatch, Ben Z. | Lafayette | Tippecanoe |
| Klaus, Julius M. | Gary | Lake |
| Kleifgen, William A. | Fort Wayne | Allen |
| Klein, Emanuel | Bloomington | Owen-Monroe |
| Kleindorfer, Roscoe L. | Evansville | Vanderburgh |
| Kleopfer, Ronald G. | Fort Wayne | Allen |
| Klepfer, Jefferson F. | Richmond | Wayne-Union |
| Klepinger, Harry E. | Lafayette | Tippecanoe |
| Klingerman, John J. | Indianapolis | Marion |
| Klooze, Kenneth W. | Fort Wayne | Allen |
| Klutinoty, George II | Indianapolis | Marion |
| Kmak, Chester J. | East Chicago | Lake |
| Knapp, Arthur L. (S) | South Bend | St. Joseph |
| Kneidel, John H. | Indianapolis | Marion |
| Knight, Lewis W. | Fort Wayne | Allen |
| Knockel, Wayne L. | Rochester | Fulton |
| Knode, Kenneth T. | South Bend | St. Joseph |
| Knotts, Halleck S. | Columbus | Bartholomew-Brown |
| Knotts, Slater | Columbus | Jackson-Jennings |
| Knowles, Charles Y. | Indianapolis | Marion |
| Knowles, Robert P. | Indianapolis | Marion |
| Ko, Richard C. B. | Gaston | Delaware-Blackford |
| Kobrin, Meyer W. | Gary | Lake |
| Koch, Edwin F., Jr. | Muncie | Delaware-Blackford |
| Koch, Elmer L. | Danville | Hendricks |
| Koch, Howard W. | Winchester | Randolph |
| Kochell, Richard L. | Indianapolis | Marion |
| Koehler, Elmer G. | Elkhart | Elkhart |
| Koenig, Robert L. | Valparaiso | Porter |
| Kohlstaedt, Karl C. | Indianapolis | Marion |
| Kohlstaedt, Kenneth G. | Indianapolis | Marion |
| Kohne, Gerald J. | Decatur | Adams |
| Kohne, Robert W. | Lafayette | Tippecanoe |
| Kolanko, Leon A. | Hammond | Lake |
| Kolettis, John G. | Gary | Lake |
| Kooiker, John E. | Indianapolis | Marion |
| Koons, Karl M. (S) | Indianapolis | Marion |
| Koontz, William A. | Gas City | Grant |
| Kopanko, Bernard F. | East Chicago | Lake |
| Kopcha, Joseph E. | Gary | Lake |
| Kopecky, Robert R. | Indianapolis | Marion |
| Kopp, William R. | Anderson | Madison |
| Koransky, David S. | Hammond | Lake |
| Korn, Jerome M. | Gary | Lake |
| Kornafel, L. H. | Indianapolis | Marion |
| Koss, K. William | Muncie | Delaware-Blackford |
| Kott, Alexander | Munster | Lake |
| Kourany, Edgar | Mooresville | Morgan |
| Kourany, Oscar | Mooresville | Morgan |
| Krabill, Willard S. | Goshen | Elkhart |
| Kraft, Bennett | Indianapolis | Marion |
| Kraft, Haldon | Noblesville | Hamilton |
| Kraning, Kenneth K. | Kewanna | Fulton |
| Krause, Frederick | Elkhart | Elkhart |
| Kreitl, Dorothy R. | Richmond | Wayne-Union |
| Kremers, George A. | Kokomo | Howard |
| Kremp, Richard E. | Indianapolis | Marion |
| Kresler, Leon E. | Kentland | Newton |
| Kress, James W. | Muncie | Delaware-Blackford |
| Krieble, William W. | Terre Haute | Vigo |
| Kriel, William B. | Indianapolis | Marion |
| Krsek, Archie J. | Hobart | Lake |
| Krueger, John E. | Fort Wayne | Allen |
| Krueger, John E. | South Bend | St. Joseph |
| Krueger, Robert B. | Columbus | Bartholomew-Brown |
| Kruse, Walter E. | Fort Wayne | Allen |
| Kubik, Francis J. | Michigan City | La Porte |
| Kubley, James D. | Plymouth | Marshall |
| Kudele, Louis T. | Whiting | Lake |
| Kuhn, Arthur J. | Hammond | Lake |
| Kuhn, Frederick L. | South Bend | St. Joseph |
| Kuhn, Hedwig S. | Hammond | Lake |
| Kuhn, Robert W. | Wilkinson | Hancock |
| Kuipers, Fred M. | Lafayette | Tippecanoe |
| Kunkler, Arnold W. | Terre Haute | Vigo |
| Kunkler, Joseph (S) | Terre Haute | Vigo |

| Name | City | County |
|---|---|---|
| Kunkler, William C. (S) | Terre Haute | Vigo |
| Kuntz, Herman W. | Indianapolis | Marion |
| Kurlander, Gerald J. | Indianapolis | Marion |
| Kurtz, Fred B. (S) | Indianapolis | Marion |
| Kurtz, Philip L. | Indianapolis | Marion |
| Kurtz, Richard | Ft. Riley, Kansas | Marion |
| Kurtz, William A. | Tipton | Tipton |
| Kwitny, Isadore J. | Indianapolis | Marion |

## L

| | | |
|---|---|---|
| LaBier, Clarence R., Jr. | Terre Haute | Vigo |
| Lackey, John T. | Indianapolis | Marion |
| Ladig, Donald S. | Fort Wayne | Allen |
| LaDine, Clarence B. | Indianapolis | Marion |
| LaDuron, Jules F. (S) | Muncie | Delaware-Blackford |
| LaFollette, Donald R. | New Albany | Floyd |
| LaFollette, Forrest R. | Hammond | Lake |
| LaFollette, Robert E. | New Albany | Floyd |
| Lahr, Richard E. | Marion | Grant |
| Laker, Gene C. | Fort Wayne | Allen |
| Laker, Richard J. | Fort Wayne | Allen |
| Lamb, Emmett B. | Indianapolis | Marion |
| Lamb, J. Leonard | South Bend | St. Joseph |
| Lamb, Russell W. | Indianapolis | Marion |
| Lamber, Chet K. | Indianapolis | Marion |
| Lamey, James L. | Anderson | Madison |
| Lamey, Paul T. | Anderson | Madison |
| Lamkin, E. Henry, Jr. | Indianapolis | Marion |
| Lampe, Elfred H. | Fort Wayne | Allen |
| Lancet, Robert O. | Terre Haute | Vigo |
| Land, Francis L. | Fort Wayne | Allen |
| Land, Richard N. | Anderson | Madison |
| Landis, Charles B. | Lafayette | Tippecanoe |
| Landon, David J. | Union City | Randolph |
| Lands, Robert M. | Portage | Porter |
| Landwehr, Alfons | Indianapolis | Marion |
| Lane, C. Elaine | Indianapolis | Marion |
| Lane, William H. | South Bend | St. Joseph |
| Lang, Erich K. | Indianapolis | Marion |
| Lang, Jay W. | Indianapolis | Marion |
| Langohr, John L. | Columbia City | Whitley |
| Langrall, Harrison M., Jr. | Marion | Grant |
| Lanman, John U. | Munster | Lake |
| Lanning, R. Adrian | Noblesville | Hamilton |
| Lansford, Kenneth G. | La Porte | La Porte |
| Largaespada, Manuel | Indianapolis | Marion |
| Larmore, Joseph L. | Anderson | Madison |
| Larrabee, James F. | Munster | Lake |
| Larzelere, Henry B. | Marion | Grant |
| Larson, Goyt O. | La Porte | La Porte |
| LaSalle, Richard M. | Wabash | Wabash |
| LaSalle, Robert M., Jr. | Wabash | Wabash |
| LaSalle, Robert M., Sr. | Wabash | Wabash |
| Lashmet, Michael H. | Indianapolis | Marion |
| Lasich, Anthony R. | Indianapolis | Marion |
| Laubscher, Clarence | Evansville | Vanderburgh |
| Laudeman, Walter A. | Elwood | Madison |
| Lautz, Herbert A. | Hammond | Lake |
| Lavengood, Russell W. | Marion | Grant |
| Lawler, George F. | Cape Coral, Florida | Marion |
| Lawler, John F. | Evansville | Vanderburgh |
| Lawrance, Kingsley | Indianapolis | Marion |
| Lawrence, John O. | Michigan City | La Porte |
| Lawrence, Joseph C. | Evansville | Vanderburgh |
| Lawson, Allan J. | Indianapolis | Marion |
| Lawson, Isaac H. (S) | Kendallville | Noble |
| Lawson, Lawrence J. | Muncie | Delaware-Blackford |
| Laycock, Richard M. | Fort Wayne | Allen |
| Leahy, Howard J. | Pendleton | Madison |
| Leak, Robert H. | Boswell | Benton |
| Leasure, J. Kent (S) | Indianapolis | Marion |
| Leatherman, Harter L. | Indianapolis | Marion |
| Lebioda, Henry S. | Gary | Lake |
| Lee, Glen Ward | Richmond | Wayne-Union |
| Lee, James | Terre Haute | Vigo |
| Lee, John M. (S) | Rushville | Rush |
| Lee, John W. | Fort Wayne | Allen |
| Lee, Robert Y. | Valparaiso | Porter |
| Leffel, James M. | Indianapolis | Marion |
| Leffler, William T. | Indianapolis | Marion |
| Lehman, David P. | Kokomo | Howard |
| Lehman, Emery W. | Bluffton | Wells |
| Lehman, Kenneth M. | Topeka | LaGrange |
| Lehmberg, Otto F. C. | Columbia City | Whitley |
| Leibundguth, Henry | Evansville | Vanderburgh |
| Leich, Charles F. | Evansville | Vanderburgh |
| Leinbach, Earl R. | Hamlet | Starke |
| LeMaster, Theodore R. | Indianapolis | Marion |
| Leming, Ben L. | Fort Wayne | Allen |
| Lenk, George G. | Fort Wayne | Allen |
| Lenox, Jack | Lebanon | Boone |
| Leroy, Alvin G. | Alexandria | Madison |
| Leser, Ralph U. | Indianapolis | Marion |
| Lessure, Alfred P. | Evansville | Vanderburgh |
| Lester, Vern L. | South Bend | St. Joseph |
| Lett, Emory B. | Loogootee | Daviess-Martin |
| Lett, James C. | Greencastle | Putnam |
| Levatin, Bernard I. | South Bend | St. Joseph |
| Levi, Leon | Indianapolis | Marion |
| Levin, Eli L. (S) | East Chicago | Lake |
| Levkoff, Abner H. | South Bend | St. Joseph |
| Lewis, Earl T. | Evansville | Vanderburgh |
| Lewis, George N. | Gary | Lake |
| Lewis, James F. | Liberty | Wayne-Union |
| Lewis, Lucien A. | Gary | Lake |
| Lewis, Paul S. | Indianapolis | Marion |
| Lewis, R. Earl | Indianapolis | Marion |
| Lewis, Robert J. | Lawrence | Marion |
| Ley, Glen D. | Bedford | Marion |
| Libbert, Edwin L., Jr. | Madison | Jefferson-Switzerland |
| Lichtenberg, Melvin | Indianapolis | Marion |
| Liddell, Charles K. | Michigan City | La Porte |
| Lidikay, Edward C. | Indianapolis | Marion |
| Life, Homer L. | New Castle | Henry |
| Lindenborg, Paul G. | Indianapolis | Marion |
| Lindgren, Ivan T. | Lawrenceburg | Dearborn-Ohio |
| Lindsay, Hamlin B. | Washington | Daviess-Martin |
| Ling, John F. | Richmond | Wayne-Union |
| Lingeman, Byron N. | Crawfordsville | Montgomery |
| Lingeman, Raleigh E. | Indianapolis | Marion |
| Lingeman, Ralph B., Jr. | Indianapolis | Marion |
| Link, Charles W., Jr. | Greenwood | Johnson |
| Link, Goethe (S) | Indianapolis | Marion |
| Link, William C. | Bloomington | Owen-Monroe |
| Lionberger, John R. | South Bend | St. Joseph |
| Lipschutz, Harold | Gary | Lake |
| Lipsey, Alfred J. | Gary | Lake |
| Liss, Emanuel C. | South Bend | St. Joseph |
| Littlefield, Paul A. | Indianapolis | Marion |
| Littlefield, Shirley D. | Indianapolis | Marion |
| Litzenberger, Sam W. | Anderson | Madison |
| Llamas, Dominador F. | North Judson | Starke |
| Lloyd, Frank P. | Indianapolis | Marion |
| Lloyd, Joe R. | Noblesville | Hamilton |
| Lloyd, Robert P. | Fort Wayne | Allen |
| Lo, Loretta S. Y. | Terre Haute | Vigo |
| Lockhart, Jack M. | Connersville | Fayette-Franklin |
| Lockhart, Philip B. | South Bend | St. Joseph |
| Loehr, William M. | Indianapolis | Marion |
| Loewenstein, Werner L. | Terre Haute | Vigo |
| Logan, James Z. | Richmond | Wayne-Union |
| Logan, Richard S. | Fort Wayne | Allen |
| Lohman, Robert M. | Fort Wayne | Allen |
| Lohoff, Lewis C. | Tell City | Perry |

| Name | County | City |
|---|---|---|
| Loh, Hwei-Ya (Chang) | Gary | Lake |
| Loh, Wei-Ping | Gary | Lake |
| Long, Keith J. | Hammond | Lake |
| Long, Malcolm D. | Indianapolis | Marion |
| Long, Max R. | Marion | Grant |
| Long, Paul L. | Anderson | Madison |
| Longshore, Robert E. | Kokomo | Howard |
| Longstaff, John P. | Evansville | Vanderburgh |
| Lonngren, Dudley H. | Marion | Grant |
| Loomis, Charles H. | Richmond | Wayne-Union |
| Loomis, Norman S. | Indianapolis | Marion |
| Loop, Frederick A. | Lafayette | Tippecanoe |
| Lopez, Alfonso | Portland | Jay |
| Lord, Glen C. | Indianapolis | Marion |
| Lorenty, Thaddeus B. | Gary | Lake |
| Lorman, James G. | Fort Wayne | Allen |
| Louden, Robert W. | Indianapolis | Marion |
| Loudermilk, Jack L. | Fort Wayne | Allen |
| Loudermilk, Richard G. | Warsaw | Kosciusko |
| Loughlin, L. Leo | Indianapolis | Marion |
| Love, George N. | Indianapolis | Marion |
| Love, V. Logan | Marion | Grant |
| Lovell, Martin H. (S) | Gary | Lake |
| Lovett, Harvey D. | Whitestown | Boone |
| Loving, Jury B. | New Goshen | Vigo |
| Lozow, David | Indianapolis | Marion |
| Lucas, Clarence A., Jr. | Indianapolis | Marion |
| Luce, John W. | Munster | Lake |
| Luckett, Coen L. (S) | Terre Haute | Vigo |
| Ludwig, Paul E. | Crawfordsville | Montgomery |
| Luginbill, Howard M. | Indianapolis | Adams |
| Lukemeyer, George T. | Indianapolis | Marion |
| Lukemeyer, St. John | Jasper | Dubois |
| Lundblad, Wilfred M. | Bloomington | Owen-Monroe |
| Lundeberg, Ralph A. | Griffith | Lake |
| Lundt, Milo O. | Elkhart | Elkhart |
| Lunsford, Thomas E. | Indianapolis | Marion |
| Lurie, Paul R. | Indianapolis | Marion |
| Luros, J. Theodore | Indianapolis | Marion |
| Luther, William C. | Elkhart | Elkhart |
| Lutz, Georgianna | Gary | Lake |
| Luzadder, John E. | New Carlisle | St. Joseph |
| Lybrook, Daniel E. (S) | Young America | Cass |
| Lybrook, William B. | Indianapolis | Marion |
| Lyman, Frank L. | Yonkers, N. Y. | Vanderburgh |
| Lynch, Harold D. | Evansville | Vanderburgh |
| Lynch, William A. | APO 207, New York, N. Y. | Marion |
| Lynn, Gene E. | Indianapolis | Marion |
| Lyon, Florence M. | Portland | Jay |
| Lyon, William C. | Fort Wayne | Allen |
| Lyons, L. Mason | Terre Haute | Vigo |
| Lyons, Robert E. | Bloomington | Owen-Monroe |
| Lytwakiwsky, Anatol | Gary | Lake |

## M

| | | |
|---|---|---|
| MacDonell, Eldred H. | South Bend | St. Joseph |
| MacDougall, John D. | Indianapolis | Marion |
| MacKenzie, Pierce | Evansville | Vanderburgh |
| McAdams, Hugh B. | Lafayette | Tippecanoe |
| McAdams, Robert | Lafayette | Tippecanoe |
| McAfee, James R. | Lebanon | Boone |
| McAleese, George B. | Terre Haute | Vigo |
| McAlpine, Richard J. | Indianapolis | Marion |
| McArdle, Edward G. | Fort Wayne | Allen |
| McAree, Francis E., Jr. | Indianapolis | Marion |
| McArt, Bruce A. | Elkhart | Elkhart |
| McAtee, Ott B. | Madison | Jefferson-Switzerland |
| McBride, James S. (S) | Indianapolis | Marion |
| McBride, Noel S. | Terre Haute | Vigo |
| McCalla, Charles X. | Paoli | Orange |
| McCallister, John W. | Fort Wayne | Allen |
| McCallister, Larry L. | Muncie | Delaware-Blackford |
| McCallum, Donald C. | Indianapolis | Marion |
| McCallum, Joseph T. C. (S) | Indianapolis | Marion |
| McCallum, Robert N. | Indianapolis | Marion |
| McCarthy, Daniel F., Jr. | New York, N. Y. | Marion |
| McCartney, Donald H. | Indianapolis | Marion |
| McCarty, Virgil | Princeton | Gibson |
| McClain, Edwin S. | Indianapolis | Marion |
| McClain, Marvin L. | Scottsburg | Scott |
| McClary, Charles W. | Bloomington | Owen-Monroe |
| McClelland, Donald C. (S) | Lafayette | Tippecanoe |
| McClintock, James A. | Muncie | Delaware-Blackford |
| McClure, Clark | Knox | Starke |
| McClure, Glen | Sullivan | Sullivan |
| McClure, Morris E. | Union City | Randolph |
| McClure, Stanley E. | Monon | White |
| McClure, Warren N. | Kokomo | Howard |
| McConnaughey, Hal D. | Great Lakes, Ill. | Marion |
| McConnell, Thomas L. | Edinburg | Johnson |
| McConnell, William C. | Sunman | Ripley |
| McCool, Joseph H. | Evansville | Vanderburgh |
| McCormack, Lloyd L. | Fremont | Steuben |
| McCormick, Charles O., Jr. | Indianapolis | Marion |
| McCormick, Hubert D. (S) | Vincennes | Knox |
| McCormick, Wilbur C. | Brazil | Clay |
| McCoy, Roy R. | Fort Wayne | Allen |
| McCraley, William J. | South Bend | St. Joseph |
| McCrea, Fred R. | Terre Haute | Vigo |
| McCullough, Henry G. | Columbus | Bartholomew-Brown |
| McCullough, James Y. | New Albany | Floyd |
| McDaniel, Franklin P. (S) | Atlanta | Hamilton |
| McDonald, Frank C. | New Castle | Henry |
| McDonald, Joseph D. | Evansville | Vanderburgh |
| McDonald, Ralph M. | South Bend | St. Joseph |
| McDonald, Virgil G. (S) | Anderson | Madison |
| McDonald, Walter E. | Gary | Lake |
| McDowell, Fletcher W. | Muncie | Delaware-Blackford |
| McDowell, George A. | Fort Wayne | Allen |
| McDowell, Mordecai M. | Vincennes | Knox |
| McEachern, Cecil G. | Fort Wayne | Allen |
| McElroy, James S. | New Castle | Henry |
| McElroy, Robert S. | Princeton | Gibson |
| McEwen, James W. | Terre Haute | Vigo |
| McFadden, James M. | Lafayette | Tippecanoe |
| McFarland, Corley B. | South Bend | St. Joseph |
| McGrath, Michael F. | Indianapolis | Marion |
| McGue, Frank J. | Michigan City | La Porte |
| McGuire, D. F. (S) | East Chicago | Lake |
| McIlroy, Richard J. | Richmond | Wayne-Union |
| McIlwain, Eleanor E. | Warren | Grant |
| McIlwain, Robert E. | Warren | Grant |
| McIndoo, Ralph E. (S) | Kokomo | Howard |
| McIntire, Clarence R. | Bloomington | Owen-Monroe |
| McIntosh, Wilbert | Riley | Vigo |
| McIntyre, Charles J. (S) | Indianapolis | Marion |
| McIntyre, James M. | Indianapolis | Marion |
| McKechnie, Robert K. | Jeffersonville | Clark |
| McKee, Harry G. | Rushville | Rush |
| McKee, Roy G. | New Castle | Henry |
| McKeeman, Donald H. | Fort Wayne | Allen |
| McKeever, Joseph W. | Marion | Grant |
| McKinley, A. David | Indianapolis | Marion |
| McKinley, Joseph | Lafayette | Tippecanoe |
| McKinney, Daniel H. | Lafayette | Tippecanoe |
| McKinney, Donald L. | Otterbein | Benton |

| Name | City | County |
|---|---|---|
| McKittrick, Jack | Washington | Daviess-Martin |
| McLain, Clarence R., Jr. | Kettering, Ohio | Marion |
| McLaren, Daniel E. | Indianapolis | Marion |
| McLaughlin, Gordon C. | Terre Haute | Vigo |
| McLaughlin, James R. | Flora | Carroll |
| McLean, James S. | Munster | Lake |
| McMahan, Virgil C. | Vincennes | Knox |
| McMath, Samuel B. | Gary | Lake |
| McMeel, James | South Bend | St. Joseph |
| McMichael, Frank J. (S) | Hernando, Fla. | Lake |
| McNabb, George B. (S) | Carthage | Rush |
| McNaughton, Lawrence | Washington | Daviess-Martin |
| McNeely, Matthew J. | Dillsboro | Dearborn-Ohio |
| McNutt, Cyrus C. | Indianapolis | Marion |
| McPherson, Richard C. | Lafayette | Tippecanoe |
| McPherson, Thomas C. | Evansville | Vanderburgh |
| McPike, Joseph D. | Bedford | Lawrence |
| McQuiston, Ralph J. | Indianapolis | Marion |
| McTurnan, Robert W. | Indianapolis | Marion |
| McVey, Clarence A. (S) | Hammond | Lake |
| McWilliams, William B. | Liberty | Wayne-Union |
| Machledt, John H. | Whiteland | Johnson |
| Mackel, Frederick O. | Fort Wayne | Allen |
| Mackey, John E. | Indianapolis | Marion |
| Macri, Paul A. | Mishawaka | St. Joseph |
| Macy, George W. | Columbus | Bartholomew-Brown |
| Madlang, Rodolfo M. | Munster | Lake |
| Madden, Robert J. | Indianapolis | Marion |
| Mader, John H. | Richmond | Wayne-Union |
| Madtson, A. Ricks | Indianapolis | Marion |
| Magennis, Herbert L. (S) | Indianapolis | Marion |
| Mahank, Camiel C. | Mishawaka | St. Joseph |
| Mahoney, Charles L. | Terre Haute | Vigo |
| Mahrt, Delmar H. | Richmond | Wayne-Union |
| Majsterek, Stanley L. | Crown Point | Lake |
| Makovsky, Theodore | Valparaiso | Porter |
| Malcolm, Russell L., Jr. | Middletown, Ohio | Marion |
| Malcolm, Russell L. | Richmond | Wayne-Union |
| Malone, Leander A. | Terre Haute | Vigo |
| Malott, Fred R. | Converse | Miami |
| Malouf, Stephen D. (S) | Peru | Miami |
| Malstaff, Comiel M. | Mishawaka | St. Joseph |
| Manalan, Maurice M. | Indianapolis | Marion |
| Manalo, Francisco S. | Gary | Lake |
| Manders, Karl L. | Indianapolis | Marion |
| Manhart, Doyle B. | Sheridan | Hamilton |
| Manifold, Harold M. | Bloomington | Owen-Monroe |
| Manion, Marlow W. | Indianapolis | Marion |
| Mankin, William J. | Terre Haute | Vigo |
| Mann, Mortimer | Indianapolis | Marion |
| Mann, Richard E. | Fort Wayne | Allen |
| Manner, Richard J. | Evansville | Vanderburgh |
| Manning, George C. | Fort Wayne | Allen |
| Manning, K. Randolph | Indianapolis | Marion |
| Mannion, Rodney A. | Michigan City | La Porte |
| Manship, C. Stanley | Paoli | Orange |
| Mansueto, Mario D. | Munster | Lake |
| Manzie, Michael W. | Indianapolis | Marion |
| Maple, James B. (S) | Sullivan | Sullivan |
| Marchand, Edwin V. | Haubstadt | Gibson |
| Marchant, Clarence H. | Bloomington | Owen-Monroe |
| Marcus, Emanuel | Hammond | Lake |
| Marcus, Morris C. (S) | Gary | Lake |
| Maris, Lee J. | Attica | Fountain-Warren |
| Mark, George A. | Elkhart | Elkhart |
| Markle, Joseph G. | Hobart | Lake |
| Marks, Howard H. | Huntington | Huntington |
| Marks, Maurice I. | Indianapolis | Marion |
| Marks, Ora L. | East Chicago | Lake |
| Marks, Salvo P. | Hammond | Lake |
| Markstone, David H. | Indianapolis | Marion |
| Maroc, James A. | Hammond | Lake |
| Marquinez, Adoracion | East Chicago | Lake |
| Marquinez, Apolinario | Highland | Lake |
| Marquis, Gordon | South Bend | St. Joseph |
| Marr, Griffith | Columbus | Bartholomew-Brown |
| Marsh, Carl M. | Indianapolis | Marion |
| Marsh, George W. | Lafayette | Tippecanoe |
| Marsh, M. Frederick | Fort Wayne | Allen |
| Marshall, Albert L., Jr. | Indianapolis | Marion |
| Marshall, Caesar L. | Fort Wayne | Allen |
| Marshall, Cavins R. (S) | Indianapolis | Marion |
| Marshall, Millard R. | Gary | Lake |
| Marshall, Thos. J. (S) | Charlestown | Clark |
| Marshall W. J., Jr. | Hammond | Lake |
| Marske, Robert L. | Michigan City | La Porte |
| Martin, Charles E. (S) | Lynn | Randolph |
| Martin, Charles F., Jr. | Minneapolis, Minn. | St. Joseph |
| Martin, Floyd S. | Goshen | Elkhart |
| Martin, Hugh E. | Indianapolis | Marion |
| Martin, Joe M. | W. Lafayette | Tippecanoe |
| Martin, Loren H. | Indianapolis | Marion |
| Martin, Paul H. | Elkhart | Elkhart |
| Martin, Samuel W. | Corydon | Harrison-Crawford |
| Martinov, William E. | South Bend | St. Joseph |
| Martirez, N. A. | East Chicago | Lake |
| Martz, Bill L. | Indianapolis | Marion |
| Martz, Carl D. | Indianapolis | Marion |
| Marvel, Howard R. | Lafayette | Tippecanoe |
| Marvel, James A. | Evansville | Vanderburgh |
| Marvel, Robert J. | Indianapolis | Marion |
| Masbaum, Ned P. | Indianapolis | Marion |
| Maschmeyer, Robert H. | Logansport | Cass |
| Mason, Bernard A. | South Bend | St. Joseph |
| Mason, Donald G. | Angola | Steuben |
| Mason, Everett E. | Evansville | Vanderburgh |
| Mason, John C. | Munster | Lake |
| Mason, Lester M. | Terre Haute | Vigo |
| Mason, Richard L. | Hammond | Lake |
| Massanari, Walter S. | Millersburg | Elkhart |
| Masters, John M. | Indianapolis | Marion |
| Masters, Robert J. (S) | Indianapolis | Marion |
| Mastrangelo, M. J. | Fort Wayne | Allen |
| Mather, Charles R. | Lafayette | Tippecanoe |
| Mather, Glenn B. | Bloomington | Owen-Monroe |
| Mather, J. Winford | East Gary | Lake |
| Mather, Robert L. | Lafayette | Tippecanoe |
| Matheu, Heracleo | Logansport | Cass |
| Mathews, James R. | Evansville | Vanderburgh |
| Mathewson, Russell C. | Muncie | Delaware-Blackford |
| Mathys, Alfred (S) | Louisville, Ky. | Harrison-Crawford |
| Matsis, John P. | Gary | Lake |
| Matthew, John R. | Westville | La Porte |
| Matthew, W. Burleigh | Indianapolis | Marion |
| Matthews, Bernard J. | Indianapolis | Marion |
| Matthews, William M. | Indianapolis | Marion |
| Mattox, Don M. | Terre Haute | Vigo |
| Matzen, Richard N. | Bluffton | Wells |
| Maurer, J. Frank | Brazil | Clay |
| Maurer, Robert M. | Brazil | Clay |
| Mauricio, Amado S. A. | Rising Sun | Dearborn-Ohio |
| Mauzy, Merritt C. | South Bend | St. Joseph |
| Maxam, B. T. | Indianapolis | Marion |
| Maxson, Roy V. | Indianapolis | Vanderburgh |
| Maxwell, Sam B. | Indianapolis | Marion |
| May, Richard M. | Gary | Lake |
| May, William D. | Rockville | Parke-Vermillion |
| Mayock, Peter P. | Bluffton | Wells |
| Mayorga, Alfredo | Gary | Lake |
| Mead, Clarence H. (S) | Bluffton | Wells |
| Mead, Frank E. | La Porte | La Porte |
| Mealey, John, Jr. | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| Medcalf, Norman L. (S) | Lamar | Spencer |
| Medina, Juan J. | East Chicago | Lake |
| Megenhardt, Dennis S. | Indianapolis | Marion |
| Mehne, Richard G. | Brazil | Clay |
| Meier, Donald W. | Bluffton | Wells |
| Meikle, Louise J. (S) | W. Lafayette | Tippecanoe |
| Meiks, Lyman T. | Indianapolis | Marion |
| Meiser, Robert D. | Huntington | Huntington |
| Meissel, Robert L. | Terre Haute | Vigo |
| Meister, Doris (S) | Anderson | Madison |
| Melin, John R. | Indianapolis | Marion |
| Mendelson, Stanley M. | Kokomo | Howard |
| Mendez, Carlos | Westville | Elkhart |
| Mensch, James R. | Fort Wayne | Allen |
| Mentendiek, Maurice H. | Indianapolis | Marion |
| Mercer, Samuel R. | Fort Wayne | Allen |
| Meredith, Elwood J. | Richmond | Wayne-Union |
| Mericle, Earl W. | Indianapolis | Marion |
| Merritt, A. Donald | Indianapolis | Marion |
| Merritt, Doris H. | Indianapolis | Marion |
| Mershon, Jack B. | Indianapolis | Marion |
| Mertz, Henry O. (S) | Atlanta, Ga. | Marion |
| Mertz, John H. O. | Indianapolis | Marion |
| Messer, Frank W. | Kendallville | Noble |
| Metcalfe, Grant E. | South Bend | St. Joseph |
| Meyer, Hans | Westville | La Porte |
| Meyer, Herman A. | Fort Wayne | Allen |
| Meyer, Theodore O. | Fort Wayne | Allen |
| Meyn, Werner P. | Eugene, Ore. | Vigo |
| Michael, Isaac E. | Indianapolis | Marion |
| Michaelis, Stephen C. | Fort Wayne | Allen |
| Middleton, Harvey N. | Indianapolis | Marion |
| Middleton, Ramona J. | Elkhart | Elkhart |
| Middleton, Thomas O. | Bloomington | Owen-Monroe |
| Miethke, Richard P. | Anderson | Madison |
| Miklozek, John E. | Terre Haute | Vigo |
| Milan, Joseph F. | Bloomington | Owen-Monroe |
| Milan, Shijachki D. | East Chicago | Lake |
| Millan, Felix | Indianapolis | Marion |
| Miller, Albert J. | Lafayette | Tippecanoe |
| Miller, Charles L. | Vincennes | Knox |
| Miller, Dan T. (S) | Fowler | Benton |
| Miller, Don E. | Fort Wayne | Allen |
| Miller, Donald C. | Cedar Lake | Lake |
| Miller, Donald G. | Elkhart | Elkhart |
| Miller, Edward D. | Fort Wayne | Allen |
| Miller, Frank H. | Indianapolis | Marion |
| Miller, Galen R. | Elkhart | Elkhart |
| Miller, Gerald L. | Markle | Huntington |
| Miller, H. Allison | Marion | Grant |
| Miller, H. Paul | Fort Wayne | Allen |
| Miller, Harold E. | Seymour | Jackson-Jennings |
| Miller, Harold L. | Richmond | Wayne-Union |
| Miller, Hugh A., Jr. | Elkhart | Elkhart |
| Miller, James | Wakarusa | Elkhart |
| Miller, James C. | Greensburg | Decatur |
| Miller, Jerry A. | Indianapolis | Marion |
| Miller, Jerry R. | Indianapolis | Marion |
| Miller, John D. | Indianapolis | Marion |
| Miller, Joseph A. | Oaklandon | Hancock |
| Miller, Kenneth D. | Woodburn | Allen |
| Miller, L. Hoyt | Indianapolis | Marion |
| Miller, LaVerne B. | Evansville | Vanderburgh |
| Miller, Mahlon F. | Fort Wayne | Allen |
| Miller, Maurice | Michigan City | La Porte |
| Miller, Milton J. | Evansville | Vanderburgh |
| Miller, Milo K. (S) | South Bend | St. Joseph |
| Miller, Orval J. | Fort Wayne | Allen |
| Miller, Ray D. | Martinsville | Morgan |
| Miller, Richard C. | Shelbyville | Shelby |
| Miller, Richard H. | Fort Wayne | Allen |
| Miller, Robert B. | Fort Wayne | Allen |
| Miller, Robert J. | Paragon | Morgan |
| Miller, Roland E. | Lafayette | Tippecanoe |
| Miller, Roscoe E. | Indianapolis | Marion |
| Miller, Samuel T. (S) | Elkhart | Elkhart |
| Miller, Virgil C. | Akron | Fulton |
| Miller, Wayne S. | Huntington | Huntington |
| Miller, William A. | Hagerstown | Henry |
| Miller, William J. | Fort Wayne | Allen |
| Miller, William J. | Lafayette | Tippecanoe |
| Milleson, Ann L. M. | Terre Haute | Vigo |
| Millis, Arthur B. | Richmond | Wayne-Union |
| Millis, Samuel C. | Crawfordsville | Montgomery |
| Mills, Fred E. | Evansville | Vanderburgh |
| Mills, John F. | Wabash | Wabash |
| Milne, Walter S. | Michigan City | La Porte |
| Milos, Robert J. | Gary | Lake |
| Minczewski, Richard C. | Gary | Lake |
| Minich, William G. | Newport | Parke-Vermillion |
| Minick, Linus J. | Churubusco | Whitley |
| Mininger, Edward P. | Elkhart | Elkhart |
| Mino, Robert A. | Evansville | Vanderburgh |
| Mintz, Alfred M. | Munster | Lake |
| Mirich, Ernest C. | Gary | Lake |
| Mirro, John A. | Lowell | Lake |
| Misch, William | Cedar Lake | Lake |
| Mishkin, Irving | Elkhart | Elkhart |
| Mishler, Joe B. | Pierceton | Whitley |
| Mitchell, John R. | Terre Haute | Vigo |
| Mitchell, George H. | Indianapolis | Marion |
| Mitchell, George L. (S) | Smithville | Owen-Monroe |
| Mitchell, Georgia B. | Gary | Lake |
| Mitchell, John B. | Evansville | Vanderburgh |
| Mladick, Edward A. | Michigan City | La Porte |
| Moak, Glenn D. | Indianapolis | Marion |
| Moats, Carl F. | Fort Wayne | Allen |
| Moats, George E. (S) | Fort Wayne | Allen |
| Mock, Harry E., Jr. | Franklin | Johnson |
| Modisett, Jackson W. | Madison | Jefferson-Switzerland |
| Modisett, Marcella S. | Madison | Jefferson-Switzerland |
| Modjeski, Joseph R. | Hammond | Lake |
| Moeller, Victor C. | Fort Wayne | Allen |
| Moenning, John E. | Greenfield | Hancock |
| Moheban, Joseph | Shelbyville | Shelby |
| Mohler, Floyd W. | Columbus | Bartholomew-Brown |
| Molengraft, Cornelius J. | Gary | Lake |
| Moleski, Walter L. | Griffith | Lake |
| Monar, Michael | Rockport | Spencer |
| Moneyhun, James E. | Anderson | Madison |
| Monroe, F. Bruce | Crown Point | Lake |
| Montes, Herminio Y. | Hammond | Lake |
| Montgomery, Lall G. | Muncie | Delaware-Blackford |
| Montgomery, Ralph F. | Muncie | Delaware-Blackford |
| Montgomery, Samuel B. (S) | Cynthiana | Posey |
| Montgomery, William F. | Indianapolis | Marion |
| Moon, Charles E. | Center Point | Clay |
| Moore, Donald F. | Indianapolis | Marion |
| Moore, Edwin G. | Gary | Lake |
| Moore, Harold T. | Indianapolis | Marion |
| Moore, Jack C. | Muncie | Delaware-Blackford |
| Moore, John M. | Kokomo | Howard |
| Moore, Richard B. | St. Paul, Minn. | Marion |
| Moore, Robert G. | Vincennes | Knox |
| Moore, Thomas C. | Muncie | Delaware-Blackford |
| Moore, William C. (S) | Muncie | Delaware-Blackford |
| Moore, William G. | La Porte | La Porte |
| Moosey, Louis | Union Mills | La Porte |
| Moran, William J. | Indianapolis | Marion |
| Moravec, Arthur E. | Fort Wayne | Allen |
| Morchan, Samuel | Indianapolis | Marion |
| Morey, Edwin E. | Fort Wayne | Allen |
| Morgan, Margaret E. | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| Morgan, Milton M. | Fort Wayne | Allen |
| Moriarty, John R. | Indianapolis | Marion |
| Morrical, Russell J. | Logansport | Cass |
| Morris, Hyman R. | Gary | Lake |
| Morris, Jean W. | Muncie | Delaware-Blackford |
| Morris, Robert A. | Anderson | Madison |
| Morris, Warren V. | Monticello | White |
| Morrison, George G., Jr. | Lawrenceburg | Dearborn-Ohio |
| Morrison, James T. | Greensburg | Decatur |
| Morrison, Lewis E. | Indianapolis | Marion |
| Morrison, William R. (S) | Kokomo | Howard |
| Morrow, Robert J. | Bedford | Lawrence |
| Morse, Arthur S. | Houston, Texas | Delaware-Blackford |
| Mortenson, Leland J. | Fort Wayne | Allen |
| Morton, David P. | Westville | La Porte |
| Morton, Joseph L. | Indianapolis | Marion |
| Morton, Walter P. | Indianapolis | Marion |
| Moser, Elmer B. (S) | Windfall | Tipton |
| Moser, Rollin H. | Indianapolis | Marion |
| Moses, George E. | Worthington | Greene |
| Moses, Robert E. | Worthington | Greene |
| Moss, Bobby L. | Indianapolis | Marion |
| Moss, Harlan B. | Indianapolis | Marion |
| Moss, Herschel C. | Indianapolis | Marion |
| Moss, Mavor J. | Yorktown | Delaware-Blackford |
| Moswin, Jack A. | Gary | Lake |
| Mothersill, Mark H. (S) | Indianapolis | Marion |
| Mott, Cassell A. | South Bend | St. Joseph |
| Mott, William H. | Gary | Lake |
| Moulton, Lillian G. | Evansville | Vanderburgh |
| Mount, Mathias S. | Bloomfield | Greene |
| Mount, William M. | Lafayette | Tippecanoe |
| Mountain, Francis B. | Connersville | Fayette-Franklin |
| Mouser, Robert W. | Indianapolis | Marion |
| Mudd, Joseph P. | Clarksville | Clark |
| Muelchi, Adeline F. | Evansville | Vanderburgh |
| Mullen, James B. | Indianapolis | Marion |
| Mueller, Edwin C. | La Porte | La Porte |
| Mueller, Hilbert M. | South Bend | St. Joseph |
| Mueller, Lawrence W. | Fort Wayne | Allen |
| Muller, Lullus P. | Indianapolis | Marion |
| Muller, Paul F. | Indianapolis | Marion |
| Muller, Victor H. | Indianapolis | Marion |
| Mullican, William S., (Jr.) | Evansville | Vanderburgh |
| Murdock, Harvey L. (S) | Fort Wayne | Allen |
| Murphy, Edward U. | Evansville | Vanderburgh |
| Murphy, Eugene C. | South Bend | St. Joseph |
| Murphy, Joseph F. | Lansing, Ill. | Lake |
| Murphy, Josephine F. | South Bend | St. Joseph |
| Murphy, Mary M. | Indianapolis | Marion |
| Murray, Ernest C. | Kokomo | Howard |
| Murray, James S. | Camarillo, Calif. | Marion |
| Murray, William E. | New Castle | Henry |
| Musselman, Glen G. | Terre Haute | Vigo |
| Myers, Charles W. (S) | Indianapolis | Marion |
| Myers, Roy V. (S) | West Palm Beach, Fla. | Marion |

## N

| Name | City | County |
|---|---|---|
| Nagan, Robert F. | Indianapolis | Marion |
| Nash, Justin R. | Albion | Noble |
| Nason, Robert A. | Garrett | De Kalb |
| Navin, Hugh K. | Fortville | Hancock |
| Navarre, Vincent J. | Munster | Lake |
| Nay, Ernest O. (S) | Terre Haute | Vigo |
| Nay, Richard M. | Indianapolis | Marion |
| Neal, Leonard W. | Munster | Lake |
| Neale, Alfred E. | Anderson | Madison |
| Nedelkoff, Bogdan | New Albany | Floyd |
| Neece, Gus W. | Muncie | Delaware-Blackford |
| Need, David J. | Indianapolis | Marion |
| Need, Louis T. | Indianapolis | Marion |
| Need, Richard L. | Agana, Guam | Marion |
| Neher, John L. | South Bend | St. Joseph |
| Neidballa, Edward G. | Bristol | Elkhart |
| Neifert, Noel L. | Tell City | Perry |
| Nelson, Carl A. | West Lebanon | Fountain-Warren |
| Nelson, F. Dale | South Bend | St. Joseph |
| Nelson, Harold E. | Muncie | Delaware-Blackford |
| Nelson, John W. | Memphis, Tenn. | Marion |
| Nelson, Raymond E. | South Bend | St. Joseph |
| Nelson, Walfred A. | Gary | Lake |
| Nenneker, Henry (S) | Evansville | Vanderburgh |
| Nesbit, Leonard L. | Anderson | Madison |
| Nester, Henry G. | Indianapolis | Marion |
| Neudorff, Louis G. | Terre Haute | Vigo |
| Neukamp, Frank H. | Connersville | Fayette-Franklin |
| Neumann, Kenneth O. | Lafayette | Tippecanoe |
| Newby, Eugene | Sheridan | Hamilton |
| Newcomb, William K. | Royal Center | Cass |
| Newman, Alvin E. (S) | Ft. Lauderdale, Fla. | Vanderburgh |
| Newman, Daniel M. | Maxwell AFB, Ala. | Marion |
| Newnam, Philip E. | Muncie | Delaware-Blackford |
| Newnum, Raymond L. | Evansville | Vanderburgh |
| Newsome, C. K. | Evansville | Vanderburgh |
| Niccum, Warren L. | Columbia City | Whitley |
| Nicholas, Dennis J. | Indianapolis | Marion |
| Nichols, Anne Sackett | Greencastle | Putnam |
| Nichols, Robert J. | Vincennes | Knox |
| Nichols, William F. | Indianapolis | Marion |
| Nicholson, Raymond W. | Evansville | Vanderburgh |
| Nicosia, John B. | East Chicago | Lake |
| Nie, Louis W. | Indianapolis | Marion |
| Niedermayer, Alfred J. | Evansville | Vanderburgh |
| Nigh, Rufus M. | Fairland | Shelby |
| Nill, John H. | Fort Wayne | Allen |
| Nixon, Byron | Farmland | Randolph |
| Noblitt, James S. (S) | Rockville | Parke-Vermillion |
| Noe, William R. | Bedford | Lawrence |
| Nohl, John M. | Indianapolis | Marion |
| Nolan, Gerald R. | Fort Wayne | Allen |
| Nolin, Richard T. | Indianapolis | Marion |
| Nolt, Ernest V. (S) | Columbia City | Whitley |
| Nolting, Henry F. (S) | Indianapolis | Marion |
| Nonte, Leo R. | Evansville | Vanderburgh |
| Noonan, Leo C. | Valparaiso | Porter |
| Norman, William H. | Indianapolis | Marion |
| Norris, Allen A. (S) | Elkhart | Elkhart |
| Norris, Marvin G. | Rushville | Rush |
| Norris, Max S. | Indianapolis | Marion |
| Norton, Harold J. | Columbus | Bartholomew-Brown |
| Norton, Horace O. | Washington | Daviess-Martin |
| Nourse, Myron H. | Indianapolis | Marion |
| Noveroske, Richard J. | Princeton | Gibson |
| Novy, Charles A. | Garrett | De Kalb |
| Nugen, Harold | Auburn | De Kalb |
| Nugent, Edwin J. | Indianapolis | Marion |
| Nurnberger, John I. | Indianapolis | Marion |
| Nutter, Wyndham H. | Rushville | Rush |

## O

| Name | City | County |
|---|---|---|
| Oak, David D., Jr. | Hanna | La Porte |
| Oak, David D., Sr. (S) | LaCrosse | La Porte |

| Name | City | County |
|---|---|---|
| Oatman, Jack G. | Fort Wayne | Allen |
| Oberlander, Seymour | Gary | Lake |
| O'Brian, Earl J. | Indianapolis | Marion |
| O'Brian, John F. | Fort Wayne | Allen |
| O'Brien, Francis E. | Rensselaer | Jasper |
| O'Brien, Raymond J. | Michigan City | La Porte |
| O'Bryan, Richard B. | Columbus | Bartholomew-Brown |
| Oca, Clemente F. | Jeffersonville | Clark |
| Ochsner, Harold C. | Indianapolis | Marion |
| Ochsner, Harold C., Jr. | Indianapolis | Marion |
| Ockerman, Kenneth R. | Rensselaer | Jasper |
| O'Connell, Noreen M. | Indianapolis | Marion |
| Offutt, Andrew C. | Indianapolis | Marion |
| Ogle, Robert W. | Greenwood | Johnson |
| Olcott, Charles W. | Aurora | Dearborn-Ohio |
| Oldag, George E. | Elwood | Madison |
| Oliphant, Frank W. | Mount Vernon | Posey |
| Oliphant, Robert W. | Terre Haute | Vigo |
| Olivo, Marciano T. | Gary | Lake |
| Olson, Donald T. | South Bend | St. Joseph |
| Olson, Kenneth L. | South Bend | St. Joseph |
| Olson, Leslie D. | Gary | Lake |
| Olvey, Ottis N. | Indianapolis | Marion |
| Omstead, Milton | Petersburg | Pike |
| O'Neill, Martin J. | Valparaiso | Porter |
| Onorato, Joseph J. | Lafayette | Tippecanoe |
| Onyett, Harold R. | Greenwood | Marion |
| Oren, William F. | South Bend | St. Joseph |
| Ornelas, Joseph P. | Gary | Lake |
| O'Rourke, Carroll | Fort Wayne | Allen |
| Orr, W. Robert | Mishawaka | St. Joseph |
| Osborne, John V. | Muncie | Delaware-Blackford |
| Oster, Jack H. | Westville | La Porte |
| Osterman, Louis H. (S) | Seymour | Jackson-Jennings |
| Ostheimer, George | Martinsville | Morgan |
| Oswald, Robert H. | Evansville | Vanderburgh |
| Oswalt, James T. | Mitchell | Lawrence |
| Otten, Claude F. | Indianapolis | Marion |
| Overley, Ross A. | Indianapolis | Marion |
| Overley, Toner M., Jr. | Indianapolis | Marion |
| Overmire, Joseph E. | Columbus | Bartholomew-Brown |
| Overpeck, Charles | Greensburg | Decatur |
| Overpeck, George H. | Alexandria | Madison |
| Overshiner, Lyman (S) | Columbus | Bartholomew-Brown |
| Owen, John E. | Indianapolis | Marion |
| Owen, Margaret T. | Bloomington | Owen-Monroe |
| Owen, Thomas F. | Alexandria | Madison |
| Owens, Tracy C. | Indianapolis | Marion |
| Owsley, Guy A. | Hartford City | Delaware-Blackford |
| Oyer, John H. | Huntsville, Texas | Allen |
| Ozalan, Necmettin H. | New London, Conn. | Dubois |

## P

| | | |
|---|---|---|
| Pace, Jerome V. | Indianapolis | Parke-Vermillion |
| Paff, William A. | Elkhart | Elkhart |
| Paine, George E. | Elkhart | Elkhart |
| Painter, Donald S. | Fort Wayne | Allen |
| Painter, Lowell W. | Winchester | Randolph |
| Pairitz, Frank D. | South Bend | St. Joseph |
| Palmer, Barron M. F. | Hammond | Lake |
| Palmer, Charman F. | Indianapolis | Marion |
| Palmer, Harley P. | Indianapolis | Marion |
| Palmer, Robert M. | Indianapolis | Marion |
| Palmer, Robert W. | Indianapolis | Marion |
| Palmer, W. Allen | Knox | Starke |
| Panares, Solomon V. | Hammond | Lake |
| Pancost, Vernon K. | Elkhart | Elkhart |
| Panos, Constantine G. | Bluffton | Wells |
| Pantzer, John G., Jr. | Indianapolis | Marion |
| Pappas, Eddie T. | Gary | Lake |
| Paras, Jose L. | Batesville | Ripley |
| Paris, Durward W. | Kokomo | Howard |
| Paris, John M. | New Albany | Floyd |
| Park, Byron J. | Richmond | Wayne-Union |
| Parker, Carey B. | Fort Wayne | Allen |
| Parker, Carl B. | Wingate | Montgomery |
| Parker, E. Camille | Logansport | Cass |
| Parker, Francis W., Jr. | Logansport | Cass |
| Parker, George F., Jr. | Indianapolis | Marion |
| Parker, Harry C. (S) | Hobart | Lake |
| Parker, John B. | Versailles | Ripley |
| Parker, John C. | Goodland | Newton |
| Parker, John F. | Indianapolis | Marion |
| Parker, Portia | Indianapolis | Marion |
| Parks, George O. | Hartford City | Delaware-Blackford |
| Parks, Herbert E. | Cincinnati, Ohio | Marion |
| Parmenter, Harry B. | Vincennes | Knox |
| Parratt, Louis W. | Gary | Lake |
| Parrish, Richard K. | Decatur | Adams |
| Parrot, Donald J. | Fort Wayne | Allen |
| Parshall, Dale B. | Elkhart | Elkhart |
| Parsons, Robert L. | South Bend | St. Joseph |
| Pascuzzi, Chris A. | South Bend | St. Joseph |
| Paskind, Jacob | Indianapolis | Marion |
| Pastor, Julius W. | Evansville | Vanderburgh |
| Patterson, Jack W. | Fort Wayne | Allen |
| Patterson, William K. | Anderson | Madison |
| Pattison, John D. | Marion | Grant |
| Paul, Eudell G. | Munster | Lake |
| Paul, Leonard G. | Michigan City | La Porte |
| Paulissen, George T. | Indianapolis | Marion |
| Paulsen, Suzanne M. | Terre Haute | Vigo |
| Pauly, Leonard R. | Fort Wayne | Allen |
| Pauszek, Thomas B. | South Bend | St. Joseph |
| Pavlick, Theodore J. | Evansville | Vanderburgh |
| Payne, Arthur C. | East Chicago | Lake |
| Paynter, Morris B. | Southport | Marion |
| Paz, Luis | Shelbyville | Shelby |
| Peacock, Norman F. | Crawfordsville | Montgomery |
| Peacock, Robert C. | Muncie | Delaware-Blackford |
| Pearce, Roy V. | Terre Haute | Vigo |
| Pearcy, Marcene | Marion | Grant |
| Peare, Reeve B. | Huntington | Huntington |
| Pearson, Huey L. | Fort Wayne | Allen |
| Pearson, John S. | Indianapolis | Marion |
| Pearson, Lyman R. | Clearwater, Fla. | Marion |
| Pearson, William E. | Wabash | Wabash |
| Peck, Edward A. | Hammond | Lake |
| Peck, Franklin B., Jr. | Indianapolis | Marion |
| Peck, Franklin B., Sr. | Indianapolis | Marion |
| Peck, James F. | Princeton | Gibson |
| Peiffer, Geraldine M. | Hammond | Lake |
| Peirce, James D. | Indianapolis | Marion |
| Pemberton, Jack J. | Evansville | Vanderburgh |
| Penn, Robert A. | East Gary | Lake |
| Pentecost, Paul S. | Richmond | Wayne-Union |
| Perkins, Powell L. | Kokomo | Howard |
| Permer, Erwin | Indianapolis | Marion |
| Perrin, Kermit F. | Fort Wayne | Allen |
| Perry, Frederic G. | Fort Wayne | Allen |
| Person, Theodore C. | Veedersburg | Fountain-Warren |
| Peters, Elmer E. | Brookville | Fayette-Franklin |
| Peterson, Deward D. | Indianapolis | Marion |
| Peterson, Joel A. | Monticello | Tippecanoe |
| Peterson, Ronald L. | Plymouth | Marshall |
| Petitjean, Harold G. | Haubstadt | Gibson |
| Petranoff, Theodore V. (S) | Indianapolis | Marion |
| Petrass, Andrew (S) | South Bend | St. Joseph |

| Name | City | County |
|---|---|---|
| Petrich, Peter R. | Attica | Fountain-Warren |
| Petry, T. Neal | Delphi | Carroll |
| Pettijohn, Fred L. (S) | Indianapolis | Marion |
| Pettis, Arthur G. | Gary | Lake |
| Peyton, Frank W. | Lafayette | Tippecanoe |
| Pfaff, Dudley A. | Indianapolis | Marion |
| Pfeifer, James M. | Lawrenceburg | Dearborn-Ohio |
| Pfuetze, Max E. | Logansport | Cass |
| Phares, Robert W. | Kokomo | Howard |
| Phelps, Stephen R. | South Bend | St. Joseph |
| Phelps, William J. | Fort Wayne | Allen |
| Philbert, Richard N. | Redwood City, Calif. | Allen |
| Philbrook, Seth S. | La Porte | La Porte |
| Phillips, David L. | Indianapolis | Marion |
| Phillips, John F. | Bluffton | Wells |
| Phillips, John H. | Michigan City | La Porte |
| Phipps, Elwood B. | Logansport | Cass |
| Phipps, Leland K. | Union City | Randolph |
| Pickerill, James M. | Lafayette | Tippecanoe |
| Pickett, Merle E. | Fort Wayne | Allen |
| Pickett, Robert D. | Indianapolis | Marion |
| Pierce, Emmett C., Jr. | Greenfield | Marion |
| Pierce, Gene S. | New Albany | Floyd |
| Pierce, Raymond O. | Indianapolis | Marion |
| Pierce, William J. | Vincennes | Daviess-Martin |
| Pierson, Howard | Gary | Lake |
| Pierson, Pearl H. | Silver Lake | Kosciusko |
| Pierson, Robert H. | Crawfordsville | Montgomery |
| Pierson, Thomas A. | New Palestine | Hancock |
| Pietz, David G. | Bluffton | Wells |
| Pike, Warren H. | Hobart | Lake |
| Pilcher, Jack E. | Indianapolis | Marion |
| Pilecki, Peter J. | Michigan City | La Porte |
| Pilot, Jean | Hammond | Lake |
| Pippenger, Joseph I. | Muncie | Delaware-Blackford |
| Pippenger, Wayne G. | Muncie | Delaware-Blackford |
| Pirkle, Hubert B. | Rockville | Parke-Vermillion |
| Pitkin, McKendree C. | Martinsville | Morgan |
| Pittman, John N. | Ann Arbor, Mich. | Marion |
| Pizzo, Anthony | Bloomington | Owen-Monroe |
| Plain, George | South Bend | St. Joseph |
| Plank, Charles R. | Michigan City | La Porte |
| Plasterer, Edward D. | Richmond | Wayne-Union |
| Platis, James M. | Gary | Lake |
| Pletcher, William D. | Elkhart | Elkhart |
| Ploetner, Edward J. | Jasper | Dubois |
| Plott, Dwight M. | Rogersville, Ala. | Marion |
| Ploughe, Ralph R. | Elwood | Madison |
| Poehler, Fred C. | La Fontaine | Wabash |
| Poland, Maynard D. | Waltham, Mass. | Marion |
| Polhemus, Warren C. | Anderson | Madison |
| Polite, Nicholas L. | Whiting | Lake |
| Poncher, John R. | Valparaiso | Vanderburgh |
| Pontius, Edwin E. | Indianapolis | Marion |
| Poolitsan, George C. | Bloomington | Owen-Monroe |
| Popp, Milton F. | Fort Wayne | Allen |
| Popplewell, Arvine G. | Indianapolis | Marion |
| Poracky, Bernard F. | Gary | Lake |
| Porro, Francis W. | Evansville | Vanderburgh |
| Porter, Carl M. | Jasonville | Greene |
| Porter, Edward A. (S) | Westport | Decatur |
| Porter, George S. | Richmond | Wayne-Union |
| Porter, Jack | Lebanon | Boone |
| Porter, Robert A. | Indianapolis | Decatur |
| Portney, Fred R. | Munster | Lake |
| Potter, Richard M. | Ridgeville | Randolph |
| Powell, J. Paxton | Marion | Grant |
| Powell, M. Jack | Fort Wayne | Allen |
| Powell, Richard C. | Indianapolis | Marion |
| Prather, Philip E. | Kokomo | Howard |
| Pratt, Ralph M., Jr. | Madison | Jefferson-Switzerland |
| Predd, Adolph C. | La Porte | La Porte |
| Premuda, Franklin F. | Hammond | Lake |
| Prentiss, Nelson H. | Oteen, N. C. | Allen |
| Present, Julian D. | Evansville | Vanderburgh |
| Price, Ambrose M. | Anderson | Madison |
| Price, Douglas W. | Nappanee | Elkhart |
| Price, Francis W. | Indianapolis | Marion |
| Price, James O. | Indianapolis | Marion |
| Price, Shirley G. | Evansville | Vanderburgh |
| Price, Walter S. | Indianapolis | Marion |
| Priddy, Marvin E. | Fort Wayne | Allen |
| Priebe, Fred H. | Indianapolis | Montgomery |
| Proudfit, Charles H. | South Bend | St. Joseph |
| Province, William D. | Franklin | Johnson |
| Pruitt, Jacob E. | Gary | Lake |
| Pryor, Richard C. | Indianapolis | Marion |
| Pu, Pin H. | Terre Haute | Vigo |
| Pugh, Willis L. | Evansville | Vanderburgh |
| Pulskamp, Bertrand H. | Wolcottville | Noble |
| Purcell, Richard J. | Griffith | Lake |
| Puterbaugh, Karl E. | Albany | Delaware-Blackford |
| Pyle, Harold D. | South Bend | St. Joseph |

## Q

| | | |
|---|---|---|
| Quick, William J. | Muncie | Delaware-Blackford |
| Quickel, Daniel S. (S) | Anderson | Madison |
| Quigley, Joseph B. | Indianapolis | Marion |
| Quilty, Thomas J. | Goshen | Elkhart |
| Quitasol, Zoilo A., Jr. | Michigan City | La Porte |

## R

| | | |
|---|---|---|
| Rabb, Aaron | Louisville, Ky. | Marion |
| Rabb, Frank M. | Indianapolis | Marion |
| Rabb, Harry S. | Indianapolis | Marion |
| Raber, Robert M. | Indianapolis | Marion |
| Radcliff, Forest F., Jr. | Evansville | Vanderburgh |
| Rader, George S. | Indianapolis | Marion |
| Radigan, Leo R. | Gary | Lake |
| Radpour, Shokri | Kokomo | Howard |
| Rafalski, Thomas A. | Indianapolis | Marion |
| Ragan, William D. | Indianapolis | Marion |
| Ralston, John D. | Indianapolis | Marion |
| Ramage, Walter F. | Beech Grove | Marion |
| Ramey, John W. (S) | Kokomo | Howard |
| Ramker, Daniel T. | Hammond | Lake |
| Ramos, John C. | East Chicago | Lake |
| Ramsdell, Glen A. | Richmond | Wayne-Union |
| Ramsey, Frank B. | Indianapolis | Marion |
| Ramsey, Hugh S. | Bloomington | Owen-Monroe |
| Ranck, Benjamin A. | Columbus | Bartholomew-Brown |
| Raney, Ben B. | Linton | Greene |
| Rang, A. A. (S) | Washington | Daviess-Martin |
| Rang, Robert H. | Washington | Daviess-Martin |
| Rank, William B. | Fort Wayne | Allen |
| Ransburg, Robert C. | Indianapolis | Marion |
| Rapp, George F. | Indianapolis | Marion |
| Rasch, George C., Jr. | Munster | Lake |
| Rasmussen, Ruth F. | South Bend | St. Joseph |
| Ratcliff, Frank W. | Lafayette | Tippecanoe |
| Ratcliffe, Albert W. | Evansville | Vanderburgh |
| Ratts, L. D. | Bloomington | Owen-Monroe |
| Rau, Charles A. | Columbus | Bartholomew-Brown |
| Rauh, Robert A. | Wabash | Wabash |
| Rausch, Norman W. | Angola | Steuben |
| Rawlins, Carolyn M. | Hammond | Lake |
| Rawls, George H. | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| Ray, Carl S. | Warren | Huntington |
| Raymundo, Vivencio F. | Attica | Fountain-Warren |
| Rea, Ralph L. | Greenfield | Hancock |
| Read, John E. | Chesterton | Porter |
| Records, Arthur W. | Franklin | Johnson |
| Records, John M. | Franklin | Johnson |
| Reed, Donald W. | Culver | Marshall |
| Reed, Edsel S. | Jeffersonville | Clark |
| Reed, Edgar A. | Warsaw | Kosciusko |
| Reed, John J. | Hobart | Lake |
| Reed, John D. | Fort Wayne | Allen |
| Reed, Nelle C. (S) | Michigan City | La Porte |
| Reed, Philip B. | Indianapolis | Marion |
| Reed, Robert C. | Terre Haute | Vigo |
| Reed, Robert F. | Mishawaka | St. Joseph |
| Reed, Robert G., Jr. | Plymouth | Marshall |
| Reed, Roger R. | Anderson | Madison |
| Reed, Ronald R. | Whiting | Lake |
| Reed, Thomas E. | Indianapolis | Marion |
| Reeder, Henry H. | Jeffersonville | Clark |
| Rees, Russel C. | Indianapolis | Marion |
| Reese, Jay S. | Martinsville | Morgan |
| Regan, George L. | Sellersburg | Clark |
| Reich, Clarence E. | Evansville | Vanderburgh |
| Reid, Charles A. | Indianapolis | Marion |
| Reid, Donald B. | Columbia City | Whitley |
| Reid, James D. | Marion | Grant |
| Reid, Robert M. | Columbus | Bartholomew-Brown |
| Reid, Robert W. (S) | Union City | Randolph |
| Reilly, Eva F. | Beech Grove | Marion |
| Reilly, James F. | Vincennes | Knox |
| Reisler, Simon (S) | Indianapolis | Marion |
| Reitman, Paul H. | East Chicago | Lake |
| Reitz, Lawrence A. | Indianapolis | Marion |
| Remich, Antone C. | Hammond | Lake |
| Renbarger, Lester L. | Marion | Grant |
| Rendel, Donald T. | Hammond | Lake |
| Rendel, Harold E. | Mexico | Miami |
| Reno, Edward C. | Plymouth | Marshall |
| Repay, Walter A. | Hammond | Lake |
| Reppert, Roland L. | Decatur | Adams |
| Ress, Gene E. | Tell City | Perry |
| Reuter, John W. | Bedford | Lawrence |
| Reynolds, James S. | Gary | Lake |
| Reynolds, Ralph E. | Middletown | Madison |
| Reynolds, Richard J. | Terre Haute | Vigo |
| Rhamy, Arthur P. | Marion | Grant |
| Rhamy, Donald E. | Indianapolis | Grant |
| Rhea, Kenneth E. | Mayport, Fla. | Marion |
| Rhee, Sang K. | New Castle | Henry |
| Rheinheimer, Floyd L. | Milford | Elkhart |
| Rhind, Alexander W. | Hammond | Lake |
| Rhodes, Alfred K. | Lawrenceburg | Dearborn-Ohio |
| Rhodes, Theodore D. | Nokomis, Fla. | Marion |
| Rhorer, Herbert M. (S) | Kokomo | Howard |
| Rhorer, John G. | Marion | Grant |
| Rhynearson, Hal R. | Fortville | Hancock |
| Ricchetti, Warren F. | Lafayette | Tippecanoe |
| Rice, Frederic A., Jr. | Indianapolis | Marion |
| Rice, Raymond D. | Indianapolis | Marion |
| Rice, Raymond M. | Indianapolis | Marion |
| Rice, Ronald B. | Indianapolis | Marion |
| Rich, Norval S. | Decatur | Adams |
| Rich, Richard B. | Indianapolis | Marion |
| Richard, Norman F. | Shelbyville | Shelby |
| Richards, Alan D. | Fort Wayne | Allen |
| Richards, Edgar E. | Russellville | Montgomery |
| Richardson, Charles L. | Rochester | Fulton |
| Richardson, Joseph D. | Rochester | Fulton |
| Richardson, Joseph H. | Marion | Grant |
| Richardson, Thad T. | Indianapolis | Marion |
| Richart, James V. | Terre Haute | Vigo |
| Richmond, Harold W. | Columbus | Bartholomew-Brown |
| Richter, Arthur B. | Indianapolis | Marion |
| Richter, John C. | La Porte | La Porte |
| Richter, Samuel | Gary | Lake |
| Ricketts, Joseph W. (S). | Orman Beach, Fla. | Marion |
| Ridgway, Alton H. | Lapel | Madison |
| Ridolfo, Anthony S. | Indianapolis | Marion |
| Rieger, I. Taylor | Bloomington | Owen-Monroe |
| Rietman, H. Jerome | Evansville | Vanderburgh |
| Rifner, Eugene S. | Van Buren | Grant |
| Rigaux, Armand J. | South Bend | St. Joseph |
| Rigg, John F. (S) | Miami Shores, Fla. | Marion |
| Riggs, Floyd C. | Terre Haute | Vigo |
| Riggs, Wendell A. | Lafayette | Tippecanoe |
| Rigley, Edward L. | South Bend | St. Joseph |
| Riley, Henry S. | Madison | Jefferson-Switzerland |
| Riley, Paul D. | Indianapolis | Marion |
| Rimel, James F. | Plymouth | Marshall |
| Rinehart, James J. | Kokomo | Howard |
| Riner, Jack K. | Indianapolis | Marion |
| Ringer, William A. | Attica | Fountain-Warren |
| Rinne, John I. (S) | Lapel | Madison |
| Riordan, John F. | Gary | Lake |
| Ripley, John W. | Seymour | Jackson-Jennings |
| Rissing, Walter J. | Fort Wayne | Allen |
| Ritchie, Richard F. | Westville | La Porte |
| Ritchie, William D. | Evansville | Vanderburgh |
| Ritchey, James O. | Indianapolis | Marion |
| Ritteman, George W. | Franklin | Johnson |
| Ritter, Wayne L. | Indianapolis | Marion |
| Ritz, Albert S. | Evansville | Vanderburgh |
| Rivers, Glynn A. | Muncie | Delaware-Blackford |
| Robb, John A. | Indianapolis | Marion |
| Roberts, Billy J. | South Bend | St. Joseph |
| Robertson, Addis N. (S) | New Albany | Floyd |
| Robertson, James S. | Plymouth | Marshall |
| Robertson, Ray B. | Indianapolis | Marion |
| Robertson, William C. | Chesterton | Porter |
| Robertson, William S. | Spiceland | Henry |
| Robinson, Earle U. | Evansville | Vanderburgh |
| Robinson, Earle U., Jr. | Indianapolis | Marion |
| Robinson, Frank C. (S) | Newport Beach, Calif. | Marion |
| Robinson, Nan | New Albany | Floyd |
| Robinson, Walter K. | Gary | Lake |
| Roby, Alma L. | Jeffersonville | Clark |
| Rochlin, Isidore | Indianapolis | Marion |
| Rockey, Noah A. (S) | Fort Wayne | Allen |
| Rodin, Herman H. | South Bend | St. Joseph |
| Roesch, Ryland P. | Indianapolis | Marion |
| Roeske, Nancy A. | Indianapolis | Marion |
| Rogers, Donald L. | Indianapolis | Marion |
| Rogers, Evered E. | Auburn | De Kalb |
| Rogers, Otto F., Jr. | Bloomington | Owen-Monroe |
| Rogers, R. Shirrell | West Terre Haute | Vigo |
| Rogers, Thomas P. | La Jolla, Calif. | Marion |
| Rohn, Robert J. | Indianapolis | Marion |
| Rohrer, Bryce B. | Walkerton | La Porte |
| Rohrer, James R. | Elnora | Daviess-Martin |
| Roller, Charles W. (S) | Indianapolis | Marion |
| Roller, Mac C. | W. Lafayette | Tippecanoe |
| Rollins, Thomas K. | Bloomington | Owen-Monroe |
| Romberger, Floyd T., Jr. | Indianapolis | Marion |
| Romero, Plinio | East Chicago | Lake |
| Rommel, Clarence H. | W. Lafayette | Tippecanoe |
| Roof, Roger S. | Spencer | Owen-Monroe |
| Roose, Lisle W. | Nappanee | Elkhart |
| Ropp, Eldon R. (S) | Oakland City | Gibson |
| Ropp, Harold E. | New Harmony | Posey |
| Rosato, Edward J. | Evansville | Vanderburgh |

| Name | City | County |
|---|---|---|
| Rosenak, Bernard D. | Indianapolis | Marion |
| Rosenbaum, Irving, Jr. | Indianapolis | Marion |
| Rosenbaum, Lloyd E. | Anderson | Madison |
| Rosenberg, Gabriel J. | Indianapolis | Marion |
| Rosenblatt, Bernard B. | Evansville | Vanderburgh |
| Rosenbloom, Philip J. | Gary | Lake |
| Rosenheimer, George M. | South Bend | St. Joseph |
| Rosenthal, Carl | Hammond | Lake |
| Rosenwasser, Jacob | Mishawaka | St. Joseph |
| Roser, Arthur J. | Fort Wayne | Allen |
| Rosero, Marciano A. | Culver | Marshall |
| Rosevear, Henry J. | Hammond | Lake |
| Ross, Alexander T. | Indianapolis | Marion |
| Ross, Ben R. | Bloomington | Owen-Monroe |
| Ross, David E., Jr. | Gary | Lake |
| Ross, Glenn E. | Washington | Daviess-Martin |
| Ross, Guy E. | Anderson | Madison |
| Ross, James B. | Bloomington | Owen-Monroe |
| Rossiter, Dudley L. | Fort Wayne | Allen |
| Roth, Bertram S. | Indianapolis | Marion |
| Roth, James R. | Columbia City | Whitley |
| Roth, Leo | Gary | Lake |
| Roth, Melvin I. | Gary | Lake |
| Rothberg, Maurice | Fort Wayne | Allen |
| Rothrock, Philip W. | Lafayette | Tippecanoe |
| Rotman, Harry G. | Jasonville | Greene |
| Rotman, Sam I. | Jasonville | Greene |
| Rouen, Robert L. | Elkhart | Elkhart |
| Rougraff, Maurice E. | Indianapolis | Marion |
| Rourke, Robert F. | Terre Haute | Vigo |
| Rousseau, John W. | Fort Wayne | Allen |
| Row, D. Hamilton | Indianapolis | Marion |
| Row, George S. | Osgood | Ripley |
| Row, Perrie Q. | Hammond | Lake |
| Rowe, Howard H. | Rochester | Fulton |
| Royster, George M. (S) | Evansville | Vanderburgh |
| Royster, Robert A. | Evansville | Vanderburgh |
| Rubens, Eli | South Bend | St. Joseph |
| Rubin, Milton M. | Terre Haute | Vigo |
| Rubin, Simon S. | Gary | Lake |
| Rubright, Robert L. | Hammond | Lake |
| Rucker, Warren R. | Madison | Jefferson-Switzerland |
| Ruddell, Karl R. (S) | Indianapolis | Marion |
| Ruddell, Keith R. | Indianapolis | Marion |
| Rudesill, Cecil L. (S) | Indianapolis | Marion |
| Rudesill, Robert L. | Indianapolis | Marion |
| Rudicel, Max | Kokomo | Howard |
| Rudolph, Carl J. | South Bend | St. Joseph |
| Rudolph, Franklin G. | Munster | Lake |
| Rudolph, Kenneth J. | Evansville | Vanderburgh |
| Rudolph, Stephen J., Jr. | APO 235, San Francisco | Marion |
| Rudser, Donald H. | Whiting | Lake |
| Rudy, Donald B. | Rhodesia, S. Africa | Wells |
| Runge, Paul W. | Richmond | Wayne-Union |
| Ruoff, William F. | New Albany | Floyd |
| Rupe, Lloyd O. | Elkhart | Elkhart |
| Rupel, Dennis F. | Elkhart | Elkhart |
| Rupper, Warren R. | Evansville | Vanderburgh |
| Rusche, Henry J. | Evansville | Vanderburgh |
| Ruschli, Edward B. (S) | Lafayette | Tippecanoe |
| Rusher, Merrill W. | Bluffton | Wells |
| Rushmore, Charles H. | Indianapolis | Marion |
| Rusk, Hubert M. | Wallace | Fountain-Warren |
| Rusler, William J. | Rochester | Fulton |
| Russell, Henry T. | Lafayette | Tippecanoe |
| Russell, John R. | Indianapolis | Marion |
| Russell, Richard H. | Evansville | Vanderburgh |
| Russo, Andrew E. | Crown Point | Lake |
| Rust, Byron K. | Indianapolis | Marion |
| Rust, Roland B. | Indianapolis | Marion |
| Ruth, Martin L. | Indianapolis | Marion |
| Rutherford, Charles E. | Indianapolis | Benton |
| Rutherford, Cyrus W. (S) | Indianapolis | Marion |
| Ryan, C. David | Indianapolis | Marion |
| Ryan, Glen V. | Indianapolis | Marion |
| Ryan, Hubert J. | Gary | Lake |
| Ryan, William J. | Columbus | Bartholomew-Brown |

## S

| | | |
|---|---|---|
| Sabens, James A. | Scottsburg | Scott |
| Sacks, Leonard Z. | Valparaiso | Porter |
| Sage, Charles V., Jr. | Richmond | Wayne-Union |
| Sage, Russell A. | Indianapolis | Marion |
| Sahlmann, Hans | Fort Wayne | Allen |
| Saint, William K. | New Castle | Henry |
| Sala, Joseph J. | Gary | Lake |
| Sala, Walter R. | Gary | Lake |
| Salb, John P. | Jasper | Dubois |
| Salb, Leo A. (S) | Jasper | Dubois |
| Salb, Max C. | Indianapolis | Marion |
| Salon, Harry W. | Fort Wayne | Allen |
| Salon, Joel W. | Fort Wayne | Allen |
| Salon, Nathan L. | Fort Wayne | Allen |
| Salzburg, Herbert E. | Westville | La Porte |
| Sanchez, Jose D. | La Porte | La Porte |
| Samter, Thomas G. | Indianapolis | Marion |
| Sanders, Bertram W. | Connersville | Fayette-Franklin |
| Sanders, Fred | Indianapolis | Marion |
| Sanders, Harry M. | Indianapolis | Marion |
| Sanders, Jesse A. (S) | Auburn | De Kalb |
| Sanders, Marilyn M. | Indianapolis | Marion |
| Sanderson, Robert B. | South Bend | St. Joseph |
| Sandock, Louis F. | South Bend | St. Joseph |
| Sandoz, Harry H. | South Bend | St. Joseph |
| Saperstein, Morris | Indianapolis | Marion |
| Santare, Vincent J. | Munster | Lake |
| Santiago, Iluminada | Highland | Lake |
| Sargent, Wallace B. | Russellville, Ala. | Lake |
| Sarver, Francis E. | Fort Wayne | Allen |
| Savage, Arthur R. | Fort Wayne | Allen |
| Sayers, Frank E. (S) | Terre Haute | Vigo |
| Scales, Alfred B. | Huntingburg | Dubois |
| Scales, Allen D. | Huntingburg | Dubois |
| Scamahorn, Malcolm O. | Pittsboro | Hendricks |
| Scea, Wallace A. | Elwood | Madison |
| Schaab, Eric | Fort Wayne | Allen |
| Schaaf, Alvin D. | Jamestown | Boone |
| Schafer, William C. | Washington | Daviess-Martin |
| Schantz, Richard | Remington | Jasper |
| Schaphorst, Richard A. | Mishawaka | St. Joseph |
| Scharbrough, Wm. D. | Ewing | Jackson-Jennings |
| Schauwecker, Cleon M. | Greencastle | Putnam |
| Schechter, John S. | Indianapolis | Marion |
| Scheer, Alexander L. | Elkhart | Elkhart |
| Scheeringa, Ronald H. | Baltimore, Md. | Marion |
| Scheier, Emil W. | Indianapolis | Marion |
| Scheimann, Lois | Valparaiso | Porter |
| Schell, H. Richard | Bloomington | Owen-Monroe |
| Schellhouse, Earl M. | Chillicothe, Ohio | Allen |
| Schenck, Ralph E. | Portland | Jay |
| Scherb, Burton E. | Terre Haute | Vigo |
| Schermer, Kenneth L. | Indianapolis | Marion |
| Scherschel, John P. | Bedford | Lawrence |
| Scheurich, Virgil | Oxford | Benton |
| Schiffer, Eva M. | Indianapolis | Marion |
| Schiller, Herbert A. | South Bend | St. Joseph |
| Schilling, Richard J. | Bloomington | Owen-Monroe |
| Schimmelpfennig, Robert W. | Evansville | Vanderburgh |
| Schirmer, Robert H. | Evansville | Vanderburgh |
| Schlademan, Karl R. | Fort Wayne | Allen |
| Schlaegel, Theo. F., Jr. | Indianapolis | Marion |
| Schlegel, Donald M. | Indianapolis | Marion |

| Name | City | County |
|---|---|---|
| Schleinkofer, Robert M. | Fort Wayne | Allen |
| Schlesinger, Daniel J. | Munster | Lake |
| Schloss, Robert P. | Fort Wayne | Allen |
| Schlosser, Herbert C. (S) | Elkhart | Elkhart |
| Schmalhausen, Ansel W. | Indianapolis | Marion |
| Schmidt, Eugene E. | Fort Wayne | Allen |
| Schmidt, Loren F. | Indianapolis | Marion |
| Schmidt, Richard H. | Valparaiso | Porter |
| Schmiedicke, Paul H. | W. Lafayette | Tippecanoe |
| Schmitt, Richard K. | Columbus | Bartholomew-Brown |
| Schmitt, Robert J. | Munster | Lake |
| Schmitt, Robert W. | Richmond | Wayne-Union |
| Schmoll, Robert J. | Fort Wayne | Allen |
| Schmoyer, Maurice R. | Indianapolis | Marion |
| Schneider, Carl J. | Indianapolis | Marion |
| Schneider, Charles P. | Evansville | Vanderburgh |
| Schneider, Kenneth D. | Columbus | Bartholomew-Brown |
| Schneider, Louis A. | Fort Wayne | Allen |
| Schneider, Marvin C. | Rushville | Rush |
| Schneider, Paul A. | Indianapolis | Marion |
| Schnute, Richard B. | Indianapolis | Marion |
| Schoen, Frederic L. | Fort Wayne | Allen |
| Schoenhals, Charles E. | Fort Wayne | Allen |
| Schoolfield, William E. | Orleans | Orange |
| Schoonveld, Arthur | Brook | Newton |
| Schott, Edward J. (S) | Terre Haute | Vigo |
| Schreiner, John E. | Bremen | Marshall |
| Schrepferman, Wayne | Hamilton | Steuben |
| Schriefer, Victor V. | Evansville | Vanderburgh |
| Schroeder, Henry R., Jr. | Washington | Daviess-Martin |
| Schroeder, Robert W. | Marion | Grant |
| Schubert, Jerome C. | Fort Wayne | Allen |
| Schuchman, Abe | Los Angeles, Calif. | Marion |
| Schuchman, Gabriel | Indianapolis | Marion |
| Schuerich, Virgil | Oxford | Benton |
| Schulhof, Maurice G. | Muncie | Delaware-Blackford |
| Schultheis, Richard L. | Bloomington | Owen-Monroe |
| Schulz, Kurt J. | Gary | Lake |
| Schumacher, Richard R. | Albany, Ga. | Marion |
| Schumaker, Robert A. | Terre Haute | Vigo |
| Schuman, Edith B. | Bloomington | Owen-Monroe |
| Schuster, Dwight W. | Indianapolis | Marion |
| Schwartz, Frederick C. | Kokomo | Howard |
| Schwartz, Jack | Munster | Lake |
| Schwartz, Mary M. | Hammond | Lake |
| Schwarz, Anton | Indianapolis | Marion |
| Schwarz, Mandel | Gary | Lake |
| Scofield, John B. | Indianapolis | Marion |
| Scoins, William H. | Fort Wayne | Allen |
| Scott, Frank M. | South Bend | St. Joseph |
| Scott, George E. | Indianapolis | Marion |
| Scott, H. Vaughn | Fort Wayne | Allen |
| Scott, Irvin H. | Sullivan | Sullivan |
| Scott, I. Winfield | Indianapolis | Marion |
| Scott, John R. | Indianapolis | Marion |
| Scott, John S. | La Porte | La Porte |
| Scott, Robert O. | Charlottesville | Hancock |
| Scott, Robert P. | Indianapolis | Marion |
| Scott, Samuel L. | Indianapolis | Marion |
| Scott, V. Brown | Shelbyville | Shelby |
| Scudder, Arthur N. | Brownsburg | Hendricks |
| Scudder, James P. | Fort Wayne | Allen |
| Scully, John T. | Gary | Lake |
| Scully, William E. | Terre Haute | Vigo |
| Seagle, William C. | Bloomington | Owen-Monroe |
| Seal, Perry F. | Brookville | Fayette-Franklin |
| Seaman, Charles F. | Indianapolis | Marion |
| Searight, Howard R. | Muncie | Delaware-Blackford |
| Searight, John L. | Indianapolis | Marion |
| Sears, Don | Odon | Daviess-Martin |
| Sears, Murray M. (S) | Elkhart | Elkhart |
| Seat, Marshall H. | Washington | Daviess-Martin |
| Sedam, Herbert L. | Indianapolis | Marion |
| Seese, Robert M. | Delphi | Carroll |
| Segar, William E. | Indianapolis | Marion |
| Segmiller, William C., Jr. | Bluffton | Wells |
| Seibel, Robert M. | Nashville | Bartholomew-Brown |
| Seipel, Stanley | Lanesville | Harrison-Crawford |
| Selby, Keith E. | South Bend | St. Joseph |
| Sellers, Francis M. | South Bend | St. Joseph |
| Sellmer, George W. | Indianapolis | Marion |
| Senese, Thomas J. | Gary | Lake |
| Sennett, Cecil M. (S) | Westville | La Porte |
| Sennett, William K. | Macy | Miami |
| Senseny, Eugene F. | Fort Wayne | Allen |
| Serna, Carlos A. | Whiting | Lake |
| Serna, Jesus A. | East Chicago | Lake |
| Seward, George W. | North Manchester | Wabash |
| Sexson, Hiram T. | Indianapolis | Marion |
| Seybert, Thomas C. | Indianapolis | Marion |
| Seyler, Anna G. | La Verne, Calif. | Lake |
| Shafer, Marion R. | Indianapolis | Marion |
| Shafer, Richard H. | Alexandria | Madison |
| Shaffer, Kenneth L. | Vincennes | Knox |
| Shaffer, William R. | Greensburg | Decatur |
| Shallenberger, Henry R. | Modoc | Randolph |
| Shanafelt, Donald K. | Indianapolis | Marion |
| Shanklin, Jack L. | Vincennes | Knox |
| Shanklin, Vernon A. (S) | Terre Haute | Vigo |
| Shanks, Ray W. | Noblesville | Hamilton |
| Shannon, Wesley E. | Crawfordsville | Montgomery |
| Shapiro, Burton J. | Indianapolis | Marion |
| Shapiro, Joseph | Hammond | Lake |
| Shapiro, Seymour W. | Hammond | Lake |
| Sharp, Merle C. | South Bend | St. Joseph |
| Sharp, William L. | Anderson | Madison |
| Shattuck, John C. | Brazil | Clay |
| Shaw, Gordon | Gary | Lake |
| Shaw, Houston W. | Jeffersonville | Clark |
| Shaw, James E. | Fort Wayne | Allen |
| Sheehan, E. Gregg | Evansville | Vanderburgh |
| Sheehan, Francis G. | Indianapolis | Marion |
| Sheek, Kenneth I. | Greenwood | Johnson |
| Sheets, Charles E. | Manilla | Rush |
| Sheldon, Suel A. | Anderson | Madison |
| Sheller, Tom G. | Logansport | Cass |
| Shelley, Edward S. | South Bend | St. Joseph |
| Shelley, Richard J. | Indianapolis | Marion |
| Shellhouse, Michael | Gary | Lake |
| Shelton, Clyde F. | New Albany | Floyd |
| Shepard, Fred F. | College Corner, Ohio | Wayne-Union |
| Sherer, Kenneth E. | Richmond | Wayne-Union |
| Sherster, Harry | Indianapolis | Marion |
| Sherwood, Clarence E. | Madison, So. Dakota | Allen |
| Shevick, Alexander | Gary | Lake |
| Shields, Jack E. | Brownstown | Jackson-Jennings |
| Shields, Tom S. | Richmond | Wayne-Union |
| Shina, Hassi S. | Charlestown | Clark |
| Shinabery, Lawerence | Fort Wayne | Allen |
| Shipley, Edward | Indianapolis | Marion |
| Shively, John L. | Lafayette | Tippecanoe |
| Shively, Wyant J. | Evansville | Vanderburgh |
| Shoemaker, Richard L. | Gas City | Grant |
| Sholty, William M. | Lafayette | Tippecanoe |
| Short, John T. (S) | Fort Wayne | Allen |
| Shoup, Homer B. (S) | Greentown | Howard |
| Showalter, John P. | Angola | De Kalb |
| Showalter, John R. | Terre Haute | Vigo |
| Shrader, Carl E. | Warsaw | Kosciusko |
| Shriber, William H. | South Bend | St. Joseph |

| Name | City | County |
|---|---|---|
| Shriner, Richard L. | South Bend | St. Joseph |
| Shrock, Ethan E. | Amboy | Miami |
| Shroyer, Herbert L. | Dunkirk | Jay |
| Shuck, William A. | Madison | Jefferson-Switzerland |
| Shugart, Robert R. | Fort Wayne | Allen |
| Shullenberger, Wendell A. | Indianapolis | Marion |
| Shulruff, Harry I. | East Chicago | Lake |
| Shultz, Clifford | Butler | De Kalb |
| Shumacker, Harris B., Jr. | Indianapolis | Marion |
| Sibbitt, Joseph W. | Bloomington | Owen-Monroe |
| Sicks, Okla W. (S) | Indianapolis | Marion |
| Sidebottom, Earl W. | Indianapolis | Marion |
| Sidell, James P. | New Haven | Allen |
| Siderys, Harry | Indianapolis | Marion |
| Siebe, Jack C. | Indianapolis | Marion |
| Siebenmorgen, Paul | Terre Haute | Vigo |
| Siegel, Lyle P. | Evansville | Vanderburgh |
| Siekierski, Joseph M. | Griffith | Lake |
| Siersdorfer, Theodore N. (S) | Indianapolis | Marion |
| Sigmond, Harvey W. | Indianapolis | Marion |
| Sigmund, William B. | Columbus | Bartholomew-Brown |
| Silber, David L., Jr. | Elkhart | Elkhart |
| Silbert, David B. | Shelbyville | Shelby |
| Siler, George B. | Whiting | Lake |
| Silver, Richard A. | Indianapolis | Marion |
| Silverman, Norman M. | Terre Haute | Vigo |
| Silvian, Harry A. | Whiting | Lake |
| Simmons, Frederick H. | Marion | Grant |
| Simmons, James E. | Indianapolis | Marion |
| Simmons, Lloyd H. (S) | Goshen | Elkhart |
| Simms, J. Leon | Indianapolis | Marion |
| Simpson, William D. | Indianapolis | Marion |
| Sims, J. Lawrence | Indianapolis | Marion |
| Singco, Bienvenido | Indianapolis | Marion |
| Singer, Elmer C. (S) | Fort Wayne | Allen |
| Sinn, Charles M. | Evansville | Vanderburgh |
| Sirlin, Edward M. | Fort Wayne | Allen |
| Sirugo, Aldo C. | La Porte | La Porte |
| Sisson, Norvel D. | South Bend | St. Joseph |
| Sixbey, Maurice D. | Denver | Miami |
| Skeen, Earl D. (S) | South Bend | Lake |
| Skillern, Penn G. (S) | South Bend | St. Joseph |
| Skillern, Scott D. | South Bend | St. Joseph |
| Skomp, Claud E. | Marion | Grant |
| Slama, George F. | Gary | Lake |
| Slama, John T. | Gary | Lake |
| Slaughter, Howard C. | Evansville | Vanderburgh |
| Slaughter, John C., Jr. | Evansville | Vanderburgh |
| Slaughter, Owen L. | Evansville | Vanderburgh |
| Slichenmyer, Jack E. | Indianapolis | Marion |
| Slick, Crystal R. | Winchester | Randolph |
| Sloan, Herbert P. | Jeffersonville | Floyd |
| Sloan, W. Keith | Madison | Jefferson-Switzerland |
| Slominski, Harry H. (S) | South Bend | St. Joseph |
| Slomka, Myron B. | Indianapolis | Marion |
| Slough, O. Thomas | Indianapolis | Noble |
| Slough, Richard R. | Kendallville | Noble |
| Sluss, David H. | Indianapolis | Marion |
| Smith, A. Wilson | Greencastle | Putnam |
| Smith, Barton T. | Marion | Grant |
| Smith, Byron J. | Kingman | Fountain-Warren |
| Smith, C. Curtis | Fort Wayne | Allen |
| Smith, Charles F. | Kokomo | Howard |
| Smith, David L. | Indianapolis | Marion |
| Smith, E. Rogers (S) | Indianapolis | Marion |
| Smith, Francis C. | Indianapolis | Marion |
| Smith, Fred, Jr. | Tell City | Perry |
| Smith, Frederick R. | Spencer | Owen-Monroe |
| Smith, Gloster J. | Kokomo | Howard |
| Smith, Gordon L. | Evansville | Vanderburgh |
| Smith, Herbert N. | Brookville | Fayette-Franklin |
| Smith, Herschel S. | Bloomington | Owen-Monroe |
| Smith, James S. | Muncie | Delaware-Blackford |
| Smith, Jerald E. | Munster | Lake |
| Smith, John H. | Greenfield | Hancock |
| Smith, Lloyd H. | North Manchester | Wabash |
| Smith, Lowell C. | Lafayette | Tippecanoe |
| Smith, Mark E. | New Castle | Henry |
| Smith, Philip L. | Fort Wayne | Allen |
| Smith, Ralph O. | Vincennes | Knox |
| Smith, Richard B. | Fort Wayne | Allen |
| Smith, Robert D. | Lowell | Lake |
| Smith, R. Lee | Osgood | Ripley |
| Smith, Roger C. | Fort Wayne | Allen |
| Smith, Roy Lee (S) | Indianapolis | Marion |
| Smith, Roy M., Jr. | Evansville | Vanderburgh |
| Smith, S. Joseph | Vincennes | Knox |
| Smith, Stephen D. | Knightstown | Rush |
| Smith, Stephen M. | Millbrook, Ala. | Marion |
| Smith, Theodore J. | Whiting | Lake |
| Smith, William M. | Westville | La Porte |
| Smitley, Roger P. | Hammond | Lake |
| Smucker, Ernest E. | Goshen | Elkhart |
| Snapp, Richard A. | Columbus | Bartholomew-Brown |
| Sneary, Max E. | Avilla | Noble |
| Snider, Byron | Escondido, Calif. | Marion |
| Snider, Roland | Warsaw | Kosciusko |
| Snively, William D., Jr. | Evansville | Vanderburgh |
| Snodgrass, Robert E. | Greenwood | Johnson |
| Snowhite, Arthur B. | Marion | Grant |
| Snyder, Jerome A. | Munster | Lake |
| Snyder, Morris C. | Richmond | Wayne-Union |
| Snyder, Parker W. | Peru | Miami |
| Snyderman, Sanford C. | Fort Wayne | Allen |
| Sobat, William S. | Indianapolis | Marion |
| Sobol, Z. W. | South Bend | St. Joseph |
| Sokol, Allen B. | Whiting | Lake |
| Solis, Roger V. | Hammond | Lake |
| Solomon, Reuben A. (S) | Indianapolis | Marion |
| Somers, Gerald H. | Fort Wayne | Allen |
| Somerville, J. W. | Clinton | Parke-Vermillion |
| Sonne, Irvin H., Jr. | New Albany | Floyd |
| Soper, Hunter A. | Indianapolis | Marion |
| Sorg, David A. | Bluffton | Wells |
| Souder, Bonnell M. (S) | Auburn | De Kalb |
| Souter, Martha C. | Indianapolis | Marion |
| Southard, Carl B. | Noblesville | Hamilton |
| Southard, James E. | Danville | Hendricks |
| Sovine, Joe W. | Indianapolis | Marion |
| Spahr, Donald E. | Portland | Jay |
| Spahr, John F., Jr. | Indianapolis | Marion |
| Spalding, David L. | Washington, D. C. | Marion |
| Spalding, Joseph J. | Indianapolis | Marion |
| Spalding, Wendell L. | Mishawaka | St. Joseph |
| Spangler, Jesse S. | Kokomo | Howard |
| Spangler, John S. | Chicago, Ill. | Marion |
| Sparks, Alan L. | Indianapolis | Marion |
| Sparks, Paul W. | Winchester | Randolph |
| Spears, John K. | Paoli | Orange |
| Spears, John M. | Indianapolis | Marion |
| Speas, Robert C. | Terre Haute | Vigo |
| Speck, Carlson R. | Muncie | Delaware-Blackford |
| Speckman, Glenn H. | Indianapolis | Marion |
| Speer, Thomas A. | Gary | Lake |
| Spellman, Frank W. | Gary | Lake |
| Spencer, Beaufort A. | Bloomington | Owen-Monroe |
| Spencer, Frederic | Vincennes | Knox |
| Spencer, C. Herbert | Fort Wayne | Allen |

| Name | City | County |
|---|---|---|
| Spenner, Raymond W. | South Bend | St. Joseph |
| Spindler, Robert D. | Shelbyville | Shelby |
| Spivack, Mary | Gary | Lake |
| Spolyar, Louis W. | Indianapolis | Marion |
| Spray, Page E. | Elkhart | Elkhart |
| Sprecher, Herman C. | Evansville | Vanderburgh |
| Sprecher, James J. J. | La Porte | La Porte |
| Springstun, George H. | Oaktown | Knox |
| Springstun, Walter R. | Evansville | Vanderburgh |
| Spurlock, Fae H. | W. Lafayette | Tippecanoe |
| Sputh, Carl B., Jr. | Indianapolis | Marion |
| Sroka, Stanley J. | Highland | Lake |
| Stadler, Harold E. | Indianapolis | Marion |
| Staff, Robert A. | Terre Haute | Parke-Vermillion |
| Stafford, William C. | Plainfield | Hendricks |
| Stahl, Edward T. | Lafayette | Tippecanoe |
| Stallings, Hugh A. | Evansville | Vanderburgh |
| Stallman, Carl F. | Kendallville | Noble |
| Stalter, Gaylord W. | North Webster | Whitley |
| Stamper, Joseph H. | Anderson | Madison |
| Stamper, Robert J. | Anderson | Madison |
| Stander, Richard W. | Indianapolis | Marion |
| Stangle, William J. | Bloomington | Owen-Monroe |
| Stanley, John R. | Muncie | Delaware-Blackford |
| Stanley, Robert G. | Fort Wayne | Allen |
| Stansbury, William E. | Indianapolis | Marion |
| Stark, William A. | Michigan City | La Porte |
| Starks, William O. | Anderson | Madison |
| Stasick, Murray | Hammond | Lake |
| Stauffer, George E. | Mooreland | Henry |
| Stauffer, Richard C. | Fort Wayne | Allen |
| Stauffer, Walter A. (S) | Elkhart | Elkhart |
| Staunton, Henry A. | South Bend | St. Joseph |
| Stayton, Chester A., Jr. | Indianapolis | Marion |
| Steckbeck, Robert L. | Bluffton | Wells |
| Stecy, Peter | Whiting | Lake |
| Steele, Dick J. | Greencastle | Putnam |
| Steele, Everett B. | Crown Point | Lake |
| Steele, Frank M. | Muncie | Delaware-Blackford |
| Steele, Hugh H. | Lafayette | Tippecanoe |
| Steele, Paul W. | Evansville | Vanderburgh |
| Steen, Lowell H. | Whiting | Lake |
| Steffen, Julius T. | Wabash | Wabash |
| Steffy, Ralph M. | Portland | Jay |
| Steigmeyer, David J. | Fort Wayne | Allen |
| Stein, Richard H. | Vincennes | Knox |
| Steinem, Joseph L. | Connersville | Fayette-Franklin |
| Steinmetz, Edward F. | Indianapolis | Marion |
| Stephens, Donald E. | Indianapolis | Marion |
| Stephens, James P. | Greencastle | Putnam |
| Stephens, Kuhrman H. | Indianapolis | Marion |
| Stephens, Lowell R. | Covington | Fountain-Warren |
| Stepleton, John D. | Richmond | Wayne-Union |
| Stern, Mona K. | Gary | Lake |
| Stern, Samuel L. | Hammond | Lake |
| Sterne, John H. | Evansville | Vanderburgh |
| Stetson, John B. | Indianapolis | Marion |
| Steury, Ernest M. | Kenya, Africa | Marion |
| Steussy, Calvin N. | New Castle | Henry |
| Stevens, Adam C. | Bluffton | Wells |
| Stevens, Edwin W. | Munster | Lake |
| Stevens, Sydney L. | Indianapolis | Marion |
| Stewart, J. Frank W. | Vincennes | Knox |
| Stewart, L. Ray | Evansville | Vanderburgh |
| Stewart, Walter E. (S) | Terre Haute | Vigo |
| Stibbins, Warren E. | Muncie | Delaware-Blackford |
| Stier, Paul L. | Fort Wayne | Allen |
| Stilwell, William R. | Richmond | Wayne-Union |
| Stine, Marshall E. | Bremen | Marshall |
| Stinson, Dean K. | Rochester | Fulton |
| Stinson, William M. | Anderson | Madison |
| Stiver, Daniel D. | South Bend | St. Joseph |
| Stoelting, J. Lewis | Terre Haute | Vigo |
| Stoelting, Vergil K. | Indianapolis | Marion |
| Stogdill, William J. | South Bend | St. Joseph |
| Stogsdill, Willis W. | Franklin | Johnson |
| Stoltz, Robert M. | Valparaiso | Porter |
| Stone, Alvin T. | Indianapolis | Marion |
| Stone, Robert C. | Ligonier | Noble |
| Stonier, Peter F. | Indianapolis | Marion |
| Stookey, Richard D. | Hobart | Lake |
| Stoops, Jean T. | Wabash | Wabash |
| Storey, D. Edmund | Indianapolis | Marion |
| Storey, Joseph L. | Indianapolis | Marion |
| Stork, Harvey K. | Huntingburg | Dubois |
| Stork, Urban F. D. | Evansville | Vanderburgh |
| Storms, Roy B. (S) | Indianapolis | Marion |
| Stouder, Albert E. | Kempton | Tipton |
| Stouder, Charles E. | Ellettsville | Owen-Monroe |
| Stout, Francis E. | Muncie | Delaware-Blackford |
| Stout, Harry T. | Frankfort | Clinton |
| Stover, Wendell C. | Boonville | Warrick |
| Stoycoff, Christ M. (S) | Gary | Lake |
| Strang, William C. | Indianapolis | Marion |
| Stratigos, Joseph S. | South Bend | St. Joseph |
| Strayer, Joseph W. | Lafayette | Tippecanoe |
| Streck, Francis A. | Lawrenceburg | Dearborn-Ohio |
| Strecker, William L. | Terre Haute | Vigo |
| Streepey, Jefferson I. | New Albany | Floyd |
| Streeter, Ralph G. | Culver | Marshall |
| Streeter, Ralph T. | Indianapolis | Marion |
| Stricker, Paul J. | New Castle | Henry |
| Strehler, Don A. | Bluffton | Wells |
| Strickland, James W. | Indianapolis | Marion |
| Strickland, Neil R. | Indianapolis | Marion |
| Stringer, Drennon D. | Mishawaka | St. Joseph |
| Strom, Jack | East Chicago | Lake |
| Strong, Daniel S. (S) | Terre Haute | Vigo |
| Strueh, Paul E. | Evansville | Vanderburgh |
| Stubbins, William M. | Elkhart | Elkhart |
| Stucky, Elsworth K. | Indianapolis | Marion |
| Stucky, Jerry L. | Fort Wayne | Allen |
| Studebaker, Lloyd R. | LaGrange | LaGrange |
| Stultz, Quentin F. | Ligonier | Noble |
| Stump, Loyd K. | Indianapolis | Marion |
| Stump, Richard L. | Muncie | Delaware-Blackford |
| Stump, Thomas A. | Indianapolis | Marion |
| Stumpf, Edwin E. | New Haven | Allen |
| Stuntz, Edgar C. | Lafayette | Tippecanoe |
| Sturgis, Donald G. | Sellersburg | Clark |
| Suelzer, John G. | Indianapolis | Marion |
| Suess, Robert E. | Indianapolis | Marion |
| Sugarman, Benjamin E. | French Lick | Orange |
| Sullivan, James J. | Indianapolis | Marion |
| Sullivan, John M. | Terre Haute | Vigo |
| Sullivan, Robert E. | Fort Wayne | Allen |
| Summerlin, Jack D. | Indianapolis | Marion |
| Sun, Chen T. | Hebron | Porter |
| Surratt, Mary Norris | Indianapolis | Marion |
| Sutton, William E. | Indianapolis | Marion |
| Suzuki, Tsutomu T. | Covington | Fountain-Warren |
| Swan, John R. | Indianapolis | Marion |
| Swank, Lucretia R. | Elkhart | Elkhart |
| Sweany, Stanford K. | Munster | Lake |
| Sweet, Howard E. | Richmond | Wayne-Union |
| Swihart, Danny D. | Elkhart | Elkhart |
| Swihart, Homer R. | Elkhart | Elkhart |
| Swihart, John J. | Argos | Marshall |
| Swinton, Stan | Fort Wayne | Allen |
| Switzer, Richard W. | Indianapolis | Marion |
| Symmes, Alfred T. | Indianapolis | Marion |
| Symon, William E. | Bluffton | Wells |
| Szynal, John S. | Indianapolis | Marion |

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| | | |
|---|---|---|
| Tabaka, Francis B. | La Porte | La Porte |
| Tager, Stephen N. | Evansville | Vanderburgh |

| Name | City | County |
|---|---|---|
| Takahashi, Masato | Indianapolis | Marion |
| Talarico, Leonard H. | Rochester, N. Y. | Marion |
| Talbert, Pierre C. | Bluffton | Wells |
| Talbott, Dan E. | Indianapolis | Marion |
| Tanner, Henry S. | Indianapolis | Marion |
| Taraba, Ralph W. | Bloomington | Owen-Monroe |
| Tate, Elizabeth | Dunkirk | Jay |
| Taub, Robert G. | Michigan City | La Porte |
| Taube, Jack I. | Indianapolis | Marion |
| Tavel, Morton E. | Indianapolis | Marion |
| Taylor, Clifford C. | Indianapolis | Marion |
| Taylor, Donald R. | Muncie | Delaware-Blackford |
| Taylor, Everett C. | Upland | Grant |
| Taylor, Frederic W. | Indianapolis | Marion |
| Taylor, James A. | Anderson | Madison |
| Taylor, John R. | Palestine, Ill. | Sullivan |
| Taylor, M. Reed, Jr. | Howe | LaGrange |
| Taylor, Robert G. | Fort Wayne | Allen |
| Taylor, Wade H. (S) | Ambia | Benton |
| Teague, Frank W. | Indianapolis | Marion |
| Teal, Dorothy D. | Columbus | Bartholomew-Brown |
| Teegarden, Joseph A., Jr. | East Chicago | Lake |
| Teixler, Victor A. | Indianapolis | Marion |
| Templeton, Ames R. | Mishawaka | St. Joseph |
| Templeton, Ian S. | Seymour | Jackson-Jennings |
| Templin, David B. | Lowell | Lake |
| Tennant, David L. | Fort Wayne | Allen |
| Tepfer, Milton | Indianapolis | Marion |
| Teplinsky, Louis L. | East Chicago | Lake |
| TerBush, Edward L. | Logansport | Cass |
| Terrill, Richard W. | Fort Wayne | Allen |
| Terry, Lloyd S. | Danville | Hendricks |
| Terry, Robert H. | Boonville | Warrick |
| Test, Charles E. | Indianapolis | Marion |
| Teter, George V. | Indianapolis | Marion |
| Teters, Melvin S. (S) | Middlebury | Elkhart |
| Tether, Joseph E. | Indianapolis | Marion |
| Tetrick, Lain | Portage | Porter |
| Tharp, Donald W. | Muncie | Delaware-Blackford |
| Tharpe, Ray G. | Indianapolis | Marion |
| Thatcher, Hugh K., Jr. | Indianapolis | Marion |
| Thayer, Benet W. | North Vernon | Jackson-Jennings |
| Theobald, Sterling | Dyer | Lake |
| Thoman, Rex L. | Indianapolis | Marion |
| Thomas, Andrew C. | Hobart | Lake |
| Thomas, Charles R. | Indianapolis | Marion |
| Thomas, Daniel D. | Gary | Lake |
| Thomas, Edward P. | Indianapolis | Marion |
| Thomas, Everett W. | Warsaw | Kosciusko |
| Thomas, Fred A. | Indianapolis | Marion |
| Thomas, Gerald J. | Gary | Lake |
| Thomas, Lowell I. | Indianapolis | Marion |
| Thomas, Morris E. | Indianapolis | Marion |
| Thomas, W. Clayton | Carmel | Hamilton |
| Thompson, Alfred A. (S) | Tyner | Marshall |
| Thompson, B. Jay | Marion | Grant |
| Thompson, Claude N. | Waynetown | Montgomery |
| Thompson, Edward C. | Greencastle | Putnam |
| Thompson, Frank M. | Columbia City | Whitley |
| Thompson, John M. | South Bend | St. Joseph |
| Thompson, John R. | Marion | Grant |
| Thompson, John V. | Indianapolis | Marion |
| Thompson, Joseph F. | Indianapolis | Marion |
| Thompson, Paul D. | Indianapolis | Marion |
| Thompson, Robert A. | South Bend | St. Joseph |
| Thompson, Wayne H. | Indianapolis | Marion |
| Thompson, Wm. R. | Winamac | Pulaski |
| Thorne, Charles E. | New Castle | Henry |
| Thornton, Harold C. | Indianapolis | Marion |
| Thornton, Maurice J. | South Bend | St. Joseph |
| Throop, Frank B. | Indianapolis | Marion |
| Thurston, Harrison S. (S) | North Webster | Marion |
| Tilden, Margaret H. | Evansville | Vanderburgh |
| Tiley, George A. | Greenwood | Johnson |
| Tilka, Edward C. | Hammond | Lake |
| Tindall, George T. | Indianapolis | Marion |
| Tindall, William R. | Shelbyville | Shelby |
| Tinsley, Frank W. | Indianapolis | Marion |
| Tinsley, Walter B. (S) | Indianapolis | Marion |
| Tinsley, Walter B., Jr. | Indianapolis | Marion |
| Tipton, William R. | Greencastle | Putnam |
| Tirman, Wallace S. | South Bend | St. Joseph |
| Tischer, E. Paul | Indianapolis | Marion |
| Tisserand, John B., Jr. | Evansville | Vanderburgh |
| Todd, David D. (S) | LaJolla, Calif. | Elkhart |
| Tolbert, Robert D. | Tampa, Fla. | Knox |
| Tomak, Milton E. | Linton | Greene |
| Tomlin, Hugh M. | Muncie | Delaware-Blackford |
| Tomusk, August N. | Fort Wayne | Allen |
| Tondra, John M. | Indianapolis | Marion |
| Topolgus, James N. | Bloomington | Owen-Monroe |
| Topping, Malachi C. | Terre Haute | Vigo |
| Torella, Jose A. | Indianapolis | Marion |
| Toumey, Fred L. | Indianapolis | Marion |
| Tower, James H., Jr. | Shelbyville | Shelby |
| Tower, Thomas K. | Campbellsburg | Washington |
| Towles, Jeff H. | Fort Wayne | Allen |
| Townley, Normand T. | Kokomo | Howard |
| Townsend, James C. | Indianapolis | Marion |
| Trachtenberg, Lee | Munster | Lake |
| Tranter, William F. | Sharpsville | Tipton |
| Traver, Perry C. (S) | South Bend | St. Joseph |
| Tremain, Milton A. (S) | Adams | Decatur |
| Treon, James F. (S) | Aurora | Dearborn-Ohio |
| Trepagnier, Francis B. | East Chicago | Lake |
| Trier, Herbert P. | Fort Wayne | Allen |
| Trimble, John G. | Kokomo | Howard |
| Trout, Carl J. | Lafayette | Tippecanoe |
| Troutwine, William R. | Crown Point | Lake |
| Troy, Jack M. | Whiting | Lake |
| Troyer, Dana O. | Goshen | Elkhart |
| Troyer, George W. | Goshen | Elkhart |
| Trudgen, Spencer F. | APO 178, New York, N. Y. | Marion |
| Trusler, H. Marshall | Indianapolis | Marion |
| Trusler, Harold M. | Indianapolis | Marion |
| Tsatsos, George C. | Oak Park, Ill. | Lake |
| Tubbs, George R. (S) | Lafayette | Tippecanoe |
| Tuchman, Joseph H. | Indianapolis | Marion |
| Tucker, Warren S. | Indianapolis | Marion |
| Tuholski, James M. | Evansville | Vanderburgh |
| Tunnell, Harry D. | Michigan City | La Porte |
| Turgi, Robert W. | Gary | Lake |
| Turley, Verne L. (S) | Fowler | Benton |
| Turner, Anna Goss | Madison | Jefferson-Switzerland |
| Turner, Harold B. (S) | Bloomfield | Greene |
| Turner, Isabel B. | Evansville | Vanderburgh |
| Turner, Jack J. | Bloomfield | Greene |
| Turner, John P. | Goshen | Elkhart |
| Turner, Oscar A. (S) | Madison | Jefferson-Switzerland |
| Tweedall, Daniel C. | Evansville | Vanderburgh |
| Tyler, Edward A. | Indianapolis | Marion |
| Tyler, Frank T. (S) | New Albany | Floyd |
| Tyner, Harlan H. | Indianapolis | Marion |
| Tyrrell, Joseph J. | Calumet City, Ill. | Lake |
| Tyrrell, Thomas C. | Calumet City, Ill. | Lake |

## U

| | | |
|---|---|---|
| Ullom, Ralph B. | Indianapolis | Marion |
| Ulrey, Robert P. | Elwood | Madison |

| Name | City | County |
|---|---|---|
| Underwood, George M. | Lafayette | Tippecanoe |
| Ungemach, Willo F. | Fort Wayne | Allen |
| Urschel, Dan L. | Mentone | Kosciusko |

## V

| Name | City | County |
|---|---|---|
| Vagner, S. Bernard | South Bend | St. Joseph |
| Valencia, Monico | East Gary | Lake |
| Valenzuela, Roberto D. | Crown Point | Lake |
| Van Bokkelen, Robert W. | Mooresville | Morgan |
| Van Buskirk, Edmund L. | Lafayette | Tippecanoe |
| Van Campen, Warren M. | Huntington | Huntington |
| Vance, William C. | Terre Haute | Vigo |
| Van Denbark, Howard M. | Indianapolis | Marion |
| Van Den Bosch, Wallace R. | Lafayette | Tippecanoe |
| Vandertoll, Donald | Whiting | Lake |
| Vandivier, Robert M. | Indianapolis | Marion |
| Van Dorn, Myron J. | Indianapolis | Marion |
| Van Fleet, Josephine | Indianapolis | Marion |
| Van Fleit, William E. | South Bend | St. Joseph |
| Van Kirk, John R. | W. Lafayette | Tippecanoe |
| Van Kirk, Paul P. | Frankfort | Clinton |
| Van Meter, C. Powell | Indianapolis | Marion |
| Van Ness, William C. | Summitville | Madison |
| Van Rie, Leo P. (S) | Mishawaka | St. Joseph |
| Van Sandt, Frank A. (S) | Bloomfield | Greene |
| Van Tassel, Charles J. | Indianapolis | Marion |
| Van Vactor, Helen D. | Indianapolis | Marion |
| Van Wienen, John | Martinsville | Morgan |
| Vaughn, Walter R. | Vincennes | Knox |
| Veach, Lester W. | Bainbridge | Putnam |
| Veach, Richard L. | Bainbridge | Putnam |
| Veach, William L. | Terre Haute | Vigo |
| Vellios, Frank | Indianapolis | Marion |
| Venables, Albert J. | Evansville | Vanderburgh |
| Venis, Kemper N. | Los Angeles, Calif. | Delaware-Blackford |
| Vergara, Abelardo | East Chicago | Lake |
| Vermilya, Robert W. | Lafayette | Tippecanoe |
| Viehe, Robert W. (S) | Evansville | Vanderburgh |
| Vietzke, Paul C. F. | Valparaiso | Porter |
| Vigor, David N. | Indianapolis | Marion |
| Vincent, William A. | Evansville | Vanderburgh |
| Viney, Charles L. | Logansport | Cass |
| Vingis, Bronie A. | Greenfield | Hancock |
| Viray, Victoriano G. | Crawfordsville | Montgomery |
| Visher, John W. (S) | Evansville | Vanderburgh |
| Vivian, Donald E. | New Castle | Henry |
| Vlaskamp, Elaine M. | Muncie | Delaware-Blackford |
| Vogel, John L. | Columbia City | Whitley |
| Vogel, Lloyd A., Jr. | Fort Wayne | Allen |
| Vogel, L. John | Mount Vernon | Posey |
| Voges, Edward C. | Terre Haute | Vigo |
| Volan, George J. | Gary | Lake |
| Vollrath, Victor J. | Indianapolis | Marion |
| von Asch, George | La Porte | La Porte |
| von der Lieth, Wm. C. | Vincennes | Knox |
| Von Der Haar, Gerard | Indianapolis | Marion |
| VonderHaar, Thomas E. | Evansville | Vanderburgh |
| Voorhees, Robert J. | Wellesley, Mass. | Allen |
| Voorhies, McKinley | Gary | Lake |
| Vore, Hugh A. (S) | Highland | Lake |
| Vore, Louring W. | Plymouth | Marshall |
| Vore, Robert E. | Indianapolis | Marion |
| Vormohr, Joseph F. | Portland | Jay |
| Voss, Gert | Muncie | Delaware-Blackford |
| Voyles, Harry E. | New Albany | Floyd |
| Vurpillat, Francis J. | South Bend | St. Joseph |

## W

| Name | City | County |
|---|---|---|
| Wachob, Tom W., Jr. | Kokomo | Howard |
| Wack, James E. | South Bend | St. Joseph |
| Wade, Reynolds W. | New Haven | Allen |
| Wagner, Anabel R. | Lafayette | Tippecanoe |
| Wagner, Arthur L. | Jasper | Dubois |
| Wagner, David G. | Goshen | Elkhart |
| Wagner, Lindley H. | Lafayette | Tippecanoe |
| Wagner, Richard | Huntington | Huntington |
| Wagoner, B. D. | Union City | Randolph |
| Wagoner, George W. | Delphi | Carroll |
| Wagoner, John R. | Anderson | Madison |
| Wainscott, Clinton S., Jr. | Indianapolis | Marion |
| Wait, Jerome H. | Columbia City | Whitley |
| Waits, Chester L. | Lafayette | Tippecanoe |
| Waitt, Paul | Sheridan | Hamilton |
| Walden, Heinz J. | Terre Haute | Vigo |
| Waldo, Guy H. | Bedford | Lawrence |
| Waldo, J. Thayer | Indianapolis | Marion |
| Walerko, Frank M. | Mishawaka | St. Joseph |
| Walker, Adolph P. | East Chicago | Lake |
| Walker, Edwin M., Jr. | South Bend | St. Joseph |
| Walker, Floyd B. | Fort Wayne | Allen |
| Walker, Jack M. | Muncie | Delaware-Blackford |
| Walker, James L. (S) | La Fontaine | Wabash |
| Walker, Louis | Greensburg | Decatur |
| Walker, Thomas M. | Brownsburg | Hendricks |
| Wallace, Collins R. | Fort Wayne | Allen |
| Wallace, Elmer L. | New Albany | Floyd |
| Wallace, Hawthorne C. | Crawfordsville | Montgomery |
| Walter, Paul A. F. III | Evansville | Vanderburgh |
| Walter, Robert F. | Evansville | Vanderburgh |
| Walters, Charles E. | Mishawaka | St. Joseph |
| Walters, Edward W. | Indianapolis | Marion |
| Walters, Jack L. | Franklin | Johnson |
| Walters, William H. | Michigan City | La Porte |
| Walther, Joseph E. | Indianapolis | Marion |
| Walton, R. Lee | Marion | Grant |
| Walton, William M. | Indianapolis | Marion |
| Wang, Tieh C. | East Chicago | Lake |
| Wanninger, Horace (S) | Richmond | Wayne-Union |
| Warbinton, Fred P. | Plainfield | Hendricks |
| Ward, Gerald F. | Fort Wayne | Allen |
| Ward, James W. | South Bend | St. Joseph |
| Ward, Wesley C. | Indianapolis | Marion |
| Ware, Herbert E. | Muncie | Delaware-Blackford |
| Ware, John R. | Russiaville | Howard |
| Warfield, Chester H. | Fort Wayne | Allen |
| Warman, Alvah P. (S) | Indianapolis | Marion |
| Warn, William J. | Milan | Ripley |
| Warneke, Charles H. | Indianapolis | Marion |
| Warner, Charles L. | Evansville | Vanderburgh |
| Warren, Carroll B. | Marion | Grant |
| Warren, Lewis T. | Michigan City | La Porte |
| Warrick, Francis B. | Richmond | Wayne-Union |
| Warrick, Homer L. | Osceola | St. Joseph |
| Warriner, James B. | Indianapolis | Marion |
| Warshaw, Seymour | Columbus | Bartholomew-Brown |
| Warvel, John H., Jr. | Indianapolis | Marion |
| Warvel, John H. (S) | Indianapolis | Marion |
| Washington, Wilbert | Indianapolis | Marion |
| Wasserman, Don H. | APO 20, San Francisco, Calif. | Marion |
| Waters, George E. | Evansville | Vanderburgh |
| Watkins, James K. | Marion | Grant |
| Watring, Watson G. | Indianapolis | Marion |
| Watson, James L. | Evansville | Vanderburgh |
| Watterson, Gerald T. | Connersville | Fayette-Franklin |
| Way, James A. | Bloomington | Owen-Monroe |
| Waymire, William M. | Franklin | Johnson |
| Webb, Harry D. | Anderson | Madison |
| Webb, Lawrence C. | Dana | Parke-Vermillion |
| Weber, Edgar H. | Evansville | Vanderburgh |

| Name | City | County |
|---|---|---|
| Weber, John R. | Fort Wayne | Allen |
| Weber, Joseph G. S. | Terre Haute | Vigo |
| Webster, Paul L. | Lafayette | Tippecanoe |
| Webster, Robert K. | Brazil | Clay |
| Weddle, Chas. O. | Lebanon | Boone |
| Weeks, Patrick H. (S) | Michigan City | La Porte |
| Weems, Mallory P. | Jeffersonville | Clark |
| Wehrman, Jule O. (S) | Indianapolis | Marion |
| Weigand, Clayton G. | Indianapolis | Marion |
| Weinbaum, Jack G. | Terre Haute | Vigo |
| Weinberg, Benjamin A. | Whiting | Lake |
| Weinberg, Samuel | Marion | Grant |
| Weinberger, Myron H. | Indianapolis | Marion |
| Weinland, George C. | Columbus | Bartholomew-Brown |
| Weinstein, Edwin B. | Richmond | Wayne-Union |
| Weinstock, Adolph | Rolling Prairie | La Porte |
| Weir, Dale C. | Louisville, Ky. | LaGrange |
| Weirich, Charles I. | Butler | De Kalb |
| Weisenberger, Brockton L. | Lawrenceburg | Dearborn-Ohio |
| Weiskopf, Henry S. | Gary | Lake |
| Weisner, Richard M. | Eaton | Delaware-Blackford |
| Weiss, Albert E. | Michigan City | La Porte |
| Weiss, Eugene | South Bend | St. Joseph |
| Weiss, Henry G. (S) | Evansville | Vanderburgh |
| Weiss, Jason | Indianapolis | Marion |
| Weiss, John T. | Hobart | Lake |
| Weiss, Louis L. | Anderson | Madison |
| Weissman, Charles G. | Hammond | Lake |
| Weitemier, Raymond A. | Richmond | Wayne-Union |
| Weitzel, Roland E. | Princeton | Gibson |
| Welborn, Mell B. | Evansville | Vanderburgh |
| Welch, Norbert M. | Vincennes | Knox |
| Weldy, Bryce P. | Hartford City | Delaware-Blackford |
| Weller, Ralph D. | Rossville | Clinton |
| Weller, Wendell A. | Lafayette | Tippecanoe |
| Wells, William R. | Princeton | Gibson |
| Wenger, James E. | Nappanee | Elkhart |
| Wenzler, Paul J. | Bloomington | Owen-Monroe |
| Werry, Leslie E. (S) | Hartford City | Delaware-Blackford |
| Wertenberger, Morris D. | Richmond | Wayne-Union |
| Wesemann, Merrill M. | Franklin | Johnson |
| West, Joseph L. | Indianapolis | Marion |
| Westerman, Richard L. | Evansville | Vanderburgh |
| Westfall, B. Kemper | Indianapolis | Marion |
| Westfall, John B. | Indianapolis | Marion |
| Westhaysen, Peter V. | Munster | Lake |
| Wharton, Russell O. (S) | Gary | Lake |
| Wheeler, Barth E. | Huntington | Huntington |
| Wheeler, Byron C. | Terre Haute | Vigo |
| Wheeler, David E. | Indianapolis | Marion |
| Wheeler, Edward C. | Indianapolis | Marion |
| Whipps, Charles E. (S) | Carlisle | Sullivan |
| Whisler, Frederick M. (S) | Wabash | Wabash |
| Whitaker, Jack D. | Anderson | Madison |
| Whitcomb, Roger F. | Shelbyville | Shelby |
| White, Chester S. (S) | Paris, Ill. | Parke-Vermillion |
| White, Donald G. | South Bend | St. Joseph |
| White, Donald J. | Indianapolis | Marion |
| White, Douglas H. | Indianapolis | Marion |
| White, Gilbert H., Jr. | Hammond | Lake |
| White, Harvey E. | Farmland | Randolph |
| White, Isaac D. (S) | Anaheim, Calif. | Parke-Vermillion |
| White, James V. | Terre Haute | Vigo |
| White, John P., Jr. | Indianapolis | Marion |
| White, Jules C. | Munster | Lake |
| Whitlock, Francis C. | Mishawaka | St. Joseph |
| Whitlock, Merle E. | Mishawaka | St. Joseph |
| Wiatt, Leonard H. | Knightstown | Henry |
| Wible, James H. | Kokomo | Howard |
| Wick, Alfred A. | Fort Wayne | Allen |
| Wickstrom, Otto W., Jr. | Columbus | Bartholomew-Brown |
| Wickstrom, Otto W. | Columbus | Bartholomew-Brown |
| Widdifield, G. E. | Indianapolis | Marion |
| Wierzalis, Edward F. | Fort Wayne | Allen |
| Wiethoff, Clifford A. | Seymour | Jackson-Jennings |
| Wigh, Russell | Columbus | Bartholomew-Brown |
| Wiland, Olin K. | Richmond | Wayne-Union |
| Wilbrandt, Hans R. | Indianapolis | Marion |
| Wilder, Gordon B. | Anderson | Madison |
| Wilhelm, Agatha M. | South Bend | St. Joseph |
| Wilhelm, Guido P. | New Castle | Henry |
| Wilhelmus, C. Kenneth | Evansville | Vanderburgh |
| Wilhelmus, Charles M. (S) | Newburgh | Warrick |
| Wilhelmus, Gilbert M. | Evansville | Vanderburgh |
| Wilkens, Irvin W. | Indianapolis | Marion |
| Willan, Horace R. (S) | Martinsville | Morgan |
| Williams, Berniece M. | Fort Wayne | Allen |
| Williams, Alexander S. | Gary | Lake |
| Williams, Charles D. | Indianapolis | Marion |
| Williams, Clifford L. | Indianapolis | Marion |
| Williams, Earl K. | Frankfort | Clinton |
| Williams, Edwin D. | Gary | Lake |
| Williams, Everett W. | Columbus | Bartholomew-Brown |
| Williams, Francis M. | Anderson | Madison |
| Williams, Fred R. | Gary | Lake |
| Williams, Fielding P. | Huntingburg | Dubois |
| Williams, Harold W. | Indianapolis | Marion |
| Williams, Howard S. | Indianapolis | Marion |
| Williams, Hugh L. | Indianapolis | Marion |
| Williams, John H. | Shipshewana | LaGrange |
| Williams, Paul A. | Rensselaer | Jasper |
| Williams, Paul D. | Indianapolis | Marion |
| Williams, Robert D. | Markleville | Madison |
| Williams, Robert H. | Anderson | Madison |
| Willis, Charles F. | Evansville | Vanderburgh |
| Willison, George W. | Evansville | Vanderburgh |
| Willner, Alan | Clarksville | Clark |
| Wills, Max | Auburn | De Kalb |
| Wilms, John H. | W. Lafayette | Tippecanoe |
| Wilson, David | Evansville | Vanderburgh |
| Wilson, Fred L. | Terre Haute | Vigo |
| Wilson, Fred M. | Indianapolis | Marion |
| Wilson, Guy H. | Bicknell | Knox |
| Wilson, James M. | South Bend | St. Joseph |
| Wilson, John | Columbia City | Whitley |
| Wilson, John D. | Evansville | Vanderburgh |
| Wilson, Ned A. | Marion | Grant |
| Wilson, Norman K. | Kokomo | Howard |
| Wilson, Oliver R. | Morgantown | Morgan |
| Wilson, Orley E. | Elkhart | Elkhart |
| Wilson, Paul E. (S) | Boonville | Warrick |
| Wilson, Paul H. | Logansport | Cass |
| Wilson, Ralph | Evansville | Vanderburgh |
| Wilson, Roland B. | Fort Wayne | Allen |
| Wilson, Talmage L. | Bloomington | Owen-Monroe |
| Wilson, Wymond B. | Mentone | Kosciusko |
| Wimmer, Robert N. (S) | Michigan City | Lake |
| Wing, Herman | Gary | Lake |
| Winklepleck, A. M. | Connersville | Fayette-Franklin |
| Winter, Donald K. | Logansport | Cass |
| Winter, William P. | Martinsville | Morgan |
| Wirey, Harold R. | Indianapolis | Marion |
| Wise, Charles L. | Camden | Carroll |
| Wise, William R. | Indianapolis | Marion |
| Wiseheart, Oscar H. (S) | North Salem | Hendricks |
| Wiseheart, Robert H. | Lebanon | Boone |

| Name | City | County |
|---|---|---|
| Wiseman, V. Earle | Greencastle | Putnam |
| Wishard, Wm. N., Jr. | Indianapolis | Marion |
| Witt, William R. | Jeffersonville | Clark |
| Wixted, John F. | South Bend | St. Joseph |
| Wixted, Julia F. | South Bend | St. Joseph |
| Woerner, Thomas E. | Indianapolis | Marion |
| Wohlfeld, Gerald M. | Terre Haute | Vigo |
| Wohlfeld, Julius B. | Bedford | Lawrence |
| Wojcik, Ladislas D. | Marion | Grant |
| Wolf, Ava A. | Madison | Jefferson-Switzerland |
| Wolf, Ray H. | Madison | Jefferson-Switzerland |
| Wolf, William E. | La Porte | La Porte |
| Wolfe, Morton F. | New Albany | Floyd |
| Wolfe, Nelson A. | New Albany | Floyd |
| Wolfram, Don J. | Indianapolis | Marion |
| Wolverton, George M. | Clarksville | Clark |
| Woner, John W. | Linton | Greene |
| Wong, Norman F. | Linden | Tippecanoe |
| Wong, Samuel N. | Hammond | Lake |
| Wood, Donald E. | Indianapolis | Marion |
| Wood, Opal L. | Brazil | Clay |
| Woodard, Abram S., Jr. | Indianapolis | Marion |
| Woodbury, Clarence R. | Anderson | Madison |
| Woodbury, John W. | Marion | Grant |
| Wooden, Thomas F. | Munster | Lake |
| Woods, Arba L. (S) | Evansville | Posey |
| Woods, Wm. P. (S) | Evansville | Vanderburgh |
| Woodson, Dan E. | Evansville | Vanderburgh |
| Woodward, Ben E. | Evansville | Vanderburgh |
| Woolery, Richard H. | Bedford | Lawrence |
| Woolling, Kenneth R. | Indianapolis | Marion |
| Work, Bruce A., Jr. | Ann Arbor, Mich. | Clinton |
| Work, Bruce A. | Frankfort | Clinton |
| Work, James A., Jr. (S) | Elkhart | Elkhart |
| Worley, Ansel C. | Fort Wayne | Allen |
| Worley, Henry L. | New Albany | Floyd |
| Worley, Joseph P. | Indianapolis | Marion |
| Worley, Richard H. | Indianapolis | Marion |
| Worth, C. Willard | Milroy | Rush |
| Wrege, Malcolm L. | Indianapolis | Marion |
| Wright, Cecil S. | Anderson | Madison |
| Wright, James J. | Indianapolis | Marion |
| Wright, J. Wm., Jr. | Indianapolis | Marion |
| Wright, Wm. C. | Fort Wayne | Allen |
| Wu, Stewart | Valparaiso | Porter |
| Wunsch, Charles M. | Indianapolis | Marion |
| Wurster, Herbert C. | Mishawaka | St. Joseph |
| Wyatt, James L., III | Fort Wayne | Allen |
| Wynegar, David E. | Richmond | Wayne-Union |
| Wynn, Justice F. | Evansville | Vanderburgh |
| Wyttenbach, John E. | Indianapolis | Marion |

## Y

| | | |
|---|---|---|
| Yacko, Michael L. | Indianapolis | Marion |
| Yale, Charles A. | Fairmount | Grant |
| Yanson, Mannfredo R. S. | Oxnard, Calif. | Lake |
| Yast, Charles J. | Gary | Lake |
| Yegerlehner, Roscoe S. | Kentland | Newton |
| Yingling, Robert J. | Indianapolis | Marion |
| Yocum, Paul S., Sr. | Coral Gables, Fla. | Steuben |
| Yocum, Paul S., Jr. | Gary | Lake |
| Yocum, William S. | Gary | Lake |
| Yoder, C. Richard | Elkhart | Elkhart |
| Yoder, Dewey D. | Pierceton | Whitley |
| Yoder, Jonathan G. | Middlebury | Elkhart |
| Yoder, Richard P. | Bluffton | Wells |
| Young, C. Curtis, Jr. | Evansville | Vanderburgh |
| Young, George M. | Gary | Lake |
| Young, Gerald S. | Muncie | Delaware-Blackford |
| Young, James W. | Indianapolis | Marion |
| Young, John E. | Indianapolis | Marion |
| Young, John M. | Indianapolis | Marion |
| Young, John T. | Indianapolis | Marion |
| Young, Joseph W. | Greenwood | Johnson |
| Young, Ralph H. | Goshen | Elkhart |
| Young, Robert G. | Marion | Grant |
| Young, Robert L. | Gary | Lake |
| Youngs, Paul E. | New Albany | Floyd |
| Yunker, Philip E. | Howe | LaGrange |

## Z

| | | |
|---|---|---|
| Zalac, Donald A. | Michigan City | La Porte |
| Zallen, Stanley G. | East Chicago | Lake |
| Zaring, Byron K. | Columbus | Bartholomew-Brown |
| Zehr, Noah (S) | Fort Wayne | Allen |
| Zeier, Francis G. | Evansville | Vanderburgh |
| Zeiger, Irvin L. | South Bend | St. Joseph |
| Zeitler, Philip S. | Elkhart | St. Joseph |
| Zell, Evertson H. | Indianapolis | Marion |
| Zeman, Ruth E. | Indianapolis | Marion |
| Zeps, E. Frances | Indianapolis | Marion |
| Zerfas, Charles P. A. | Beech Grove | Marion |
| Zerfas, Phyllis K. | Indianapolis | Marion |
| Zimmer, Henry J. | Mishawaka | St. Joseph |
| Zimmerman, Harold | Evansville | Vanderburgh |
| Zimmerman, Wm. H. | Syracuse | Elkhart |
| Zink, Robert O. | Madison | Jefferson-Switzerland |
| Ziperman, H. Haskell | APO 403, New York, N. Y. | Marion |
| Ziss, Robert C. | Evansville | Vanderburgh |
| Zore, Joseph J. | Richmond | Wayne-Union |
| Zucker, Edward | Gary | Lake |
| Zweig, Elmer S. | Fort Wayne | Allen |
| Zwerner, Paul F. | Terre Haute | Vigo |
| Zwick, Harold F. | Decatur | Adams |
| Zwickel, Ralph E. | Evansville | Vanderburgh |
| Zydlo, Stanley M. | Wabash | Wabash |

# ROSTER OF MEMBERS BY COUNTIES

**Physicians are listed in the county medical society in which they hold membership.**

**(Paid-up members of the Indiana State Medical Association as of May 1, 1965.)**

## ADAMS COUNTY

### Berne

Beaver, Norman E. .....165 W. Water St.
Boze, Robert L. .....265 W. Water St.
Dester, Herbert E. (S).....424 Compromise St.

### Decatur

Burk, James M.....115 N. Third St.
Carroll, John C.....226 S. Second St.
Doan, John E. .....222 S. Second St.
Freeby, C. William.....227 S. Second St.
Girod, Arthur H.....203 N. 12th St.
Kohne, Gerald J.....134 S. Third St.
Parrish, Richard K.....238 S. Second St.
Reppert, Roland L.....222 S. Second St.
Rich, Norval S.....415 W. Madison
Zwick, Harold F.....227 S. Second St.

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Luginbill, Howard M.
820 W. Kessler Blvd., Indianapolis (8)

## ALLEN COUNTY

### Fort Wayne

A

Adams, E. Wade.....3124 E. State Blvd.
Ahlbrand, Roland C.....1417 N. Anthony Blvd.
Aiken, Arthur F.....3010 E. State Blvd.
Aiken, Nevin E.....3010 E. State Blvd.
Anderson, Ernest.....4349 S. Anthony Blvd.
Anderson, Garland D.....5015 Riviera Ct.
Andrew, Jerald L.....5717 S. Anthony Blvd.
Arata, James A.....730 W. Berry St.
Arata, Justin E.....3124 E. State Blvd.
Ashman, William C.....2902 S. Fairfield Ave.
Aust, Charles H.....Lutheran Hospital

B

Bahr, Robert E.....3217 Lake Ave.
Bailey, Paul P. (S).....206 Medical Center Bldg.
Ball, John R. .....320 Medical Center Bldg.
Ball, Margaret Jane.....4112 S. Harrison St.
Baltes, Joseph H.....821 Broadway
Barch, John W.....1301 S. Harrison St.
Bash, Wallace E.....2902 Fairfield Ave.
Baumgartner, Jeraldine.....515½ W. Wayne St.
Beams, Ralph H.....715 Medical Center Bldg.
Beierlein, Karl M.....3124 E. State Blvd.
Beights, Raymond S.....3310 E. State Blvd.
Bergendahl, Emil H.....102 Medical Center Bldg.
Berghoff, James R.....306 Jefferson St.
Beutler, Theodore V.....527 W. Berry St.
Bierman, Gilbert H.....402 Medical Center Bldg.
Billingsley, John S.....2902 Fairfield Ave.
Blichert, Peter A.....424 Medical Center Bldg.
Bolman, Ralph M.....717 Broadway
Bossard, John W.....115 Medical Center Bldg.
Bowers, Gah T.....3000 Circumurban Blvd.
Bowers, George W.....2902 Fairfield Ave.
Bowers, Jesse W. (S).....418 Gettle Bldg.
Brandt, William E.....618 W. Berry St.
Braunlin, Robert J.....418 Medical Center Bldg.
Bridges, William L.....520 Medical Center Bldg.
Bromley, Luman W.....2730 E. State Blvd.
Brosius, Robert H. W.....1603 Wells St.
Brown, Frederic W.....2609 Fairfield Ave.
Brown, Garland R.....730 W. Berry St.
Brucker, Perry A.....304 Medical Center Bldg.
Bryan, Franklin A.....512 Medical Center Bldg.
Buckner, George D.....1003 Fulton St.
Burkhart, Charles A.....1301 S. Harrison St.

C

Carlo, Ernest R. (S).....2902 Fairfield Ave.
Cartwright, Emor L. (S)....3718 Hiawatha Blvd.
Chambers, Alan R.....601 W. Wayne St.
Chase, James A.....1635 Broadway
Clark, William R.....3622 S. Calhoun St.
Cochran, Harry A., Jr.....1301 S. Harrison St.
Conley, John E.....620 W. Berry St.
Connelly, Jerry H.....3217 Lake Ave.
Connelly, Richard D.....3217 Lake Ave.
Cooney, Charles J.....527 W. Berry St.
Cottrell, Robert F.....234 Medical Center Bldg.
Craig, Richard M.....2902 Fairfield Ave.
Culp, John E.....2902 Fairfield Ave.

D

Datzman, Richard C.....520 Medical Center Bldg.
Davidoff, Manuel A.....3610 Brooklyn Ave.
Duemling, Arnold H...6526 Upper Huntington Rd.
Dunstone, Harry C.....502 Medical Center Bldg.

E

Elston, Lynn W. (S)....604 Medical Center Bldg.
Elston, Ralph W.....604 Medical Center Bldg.
Emenhiser, John L.....1407 Pinehurst Dr.
Engleman, Reinhold.....1301 S. Harrison St.
Epps, James H.....3318 E. State Blvd.

F

Farquhar, John S., Jr.....3610 Brooklyn Ave.
Ferguson, Arthur N.....2902 Fairfield Ave.
Fichman, Abraham M.....323 W. Berry St.
Flaherty, Robert A.....2902 Fairfield Ave.
Foy, Thomas D.....1104 W. State Blvd.
Franke, Gordon R.....3010 E. State Blvd.
Frankhouser, C. M. A., Jr.
520 Medical Center Bldg.
Fullam, Richard G.....234 Medical Center Bldg.

G

Garton, Harry W.....3603 Hamilton Road, R. R. 6
Gastineau, David C.....520 Medical Center Bldg.
Gentile, Jonathan Paul.....2156 Fairfield Ave.
Gerding, William J.....2638 S. Anthony Blvd.
Giffin, Charles S.....102 Medical Center Bldg.
Gladstone, Naf H.....335 W. Berry St.
Glassley, Stephen H.....3010 E. State Blvd.
Glock, Homer Edwin (S)
324 Medical Center Bldg.
Glock, Maurice E.....229 Medical Center Bldg.
Glock, Wayne R.....2609 Fairfield Ave.
Goebel, Carl W.....327 W. Creighton Ave.
Gould, John C.....2424 Fairfield Ave.
Graham, George M.....1301 S. Harrison St.
Graham, James C.....1834 S. Lafayette
Green, Robert F.....614 W. Berry St.
Greenlee, Robert L.....227 E. Washington St.
Greist, Walter D.....3024 Fairfield Ave.
Griffith, Harold R.....520 Medical Center Bldg.

H

Hackett, Walter G.....6028 U. Huntington Rd.
Haffner, Herman G.....202 E. Jefferson St.
Haley, Alvin J.....3217 Lake Ave.
Hall, William R.....234 Medical Center Bldg.
Haller, Richard C.....3124 E. State Blvd.
Hamilton, Emory D.....234 Medical Center Bldg.
Hamilton, George M.....3124 E. State Blvd.
Hance, Joseph W.....234 Medical Center Bldg.
Hasewinkle, August M.....2828 E. State Blvd.
Hastings, Warren C.....111 Medical Center Bldg.
Hattendorf, Anton P.....725 Medical Center Bldg.
Havens, Russell E.....228 Medical Center Bldg.
Hershberger, Philip G.....2609 Fairfield Ave.

Hickman, Donald M.....3217 Lake Ave.
Hillery, Robert L.....810 W. State Blvd.
Hipskind, Richard E.....332 E. Pontiac St.
Hoffman, Arthur F.....519 Medical Center Bldg.
Holsinger, Robert E.....115 Medical Center Bldg.
Hoover, Joseph R.....3610 Brooklyn Ave.
Howe, Fordyce L.....1525 Oxford St.
Humphreys, John L.....1301 S. Harrison St.

I

Irmscher, George W.....1417 N. Anthony Blvd.
Irmscher, Jane M.....2024 Florida Dr.
Isenogle, Kenneth F.....418 Medical Center Bldg.

J

Jackson, John F.....519 Medical Center Bldg.
Johnston, Richard M.....3318 E. State Blvd.
Jontz, Joe G.....3124 E. State Blvd.
Jontz, Richard L.....520 Medical Center Bldg.
Juergens, Richard B.....1709 Prairie Lane
Jurgensen, Walter T.....3415 Fairfield Ave.

K

Karol, Herbert J.....324 Medical Center Bldg.
Kaufman, Julian R.....3124 E. State Blvd.
Keck, Carleton A.....2902 Fairfield Ave.
Kent, Richard N.....731 Medical Center Bldg.
Keyes, Robert C.....3714 S. Calhoun St.
Kidder, Orva T.....Irene Byron Hospital
Kilgore, Byron.....2828 E. State Blvd.
Kimbrough, Robert F.....2730 E. State Blvd.
Kleifgen, William A.....446 W. Pontiac St.
Kloepfer, Ronald G.....3124 E. State Blvd.
Klooze, Kenneth W.....3610 Brooklyn Ave.
Knight, Lewis W.....3124 E. State Blvd.
Krueger, John E.....5717 S. Anthony Blvd.
Kruse, Walter E.....410 McKinnie

L

Ladig, Donald S.....337 E. Berry St.
Laker, Gene C.....2407 Fairoak Dr.
Laker, Richard J.....2407 Fairoak Dr.
Lampe, Elfred H.....2902 Fairfield Ave.
Land, Francis L.....4628 Calhoun
Laycock, Richard M.....6642 St. Joe Rd.
Lee, John W.....3124 E. State Blvd.
Leming, Ben L.....2902 Fairfield Ave.
Lenk, George G.....1805 E. Washington St.
Lloyd, Robert P.....723 Fulton St.
Logan, Richard S.....3124 E. State Blvd.
Lohman, Robert M.....4017 S. Wayne St.
Lorman, James G.....520 Medical Center Bldg.
Loudermilk, Jack L.....520 Medical Center Bldg.
Lyon, William C.....710 W. Wayne St.

M

McArdle, Edward G.....2201 S. Calhoun St.
McCallister, John W.....3124 E. State Blvd.
McCoy, Roy R.....3701 S. Harrison St.
McDowell, George A.....215 Medical Center Bldg.
McEachern, Cecil G.....2424 Fairfield Ave.
McKeeman, Donald H.....633 W. Wayne St.
Mackel, Frederick O.....2609 Fairfield Ave.
Mann, Richard E.....3124 E. State Blvd.
Manning, George C.....534 W. Berry St.
Marsh, M. Frederick.....1417 N. Anthony Blvd.
Marshall, Caesar L.....438 E. Lewis St.
Mastrangelo, Michael J....306 Medical Center Bldg.
Mensch, James R.....2120 Forest Park
Mercer, Samuel R.....702 Medical Center Bldg.
Meyer, Herman A.....1030 W. Wayne St.
Meyer, Theodore O.....622 Medical Center Bldg.
Michaelis, Stephen C.....3610 Brooklyn Ave.
Miller, Don E.....2902 Fairfield Ave.
Miller, Edward D.....1402 E. State Blvd.
Miller, H. Paul.....2715 Broadway
Miller, Mahlon F.....222 Medical Center Bldg.
Miller, Orval J.....324 W. Berry St.
Miller, Richard H.....511 W. Wayne St.
Miller, Robert B.....3124 E. State Blvd.
Miller, William J.....2902 Fairfield Ave.
Moats, Carl F.....4007 W. Wayne St.
Moats, George E. (S)....615 E. Washington Blvd.
Moeller, Victor C.....2424 Fairfield Ave.
Moravec, Arthur E.....705 Lincoln Tower
Morey, Edwin E.....2902 Fairfield Ave.
Morgan, Milton M.....1147 S. Lafayette St.
Mortenson, Leland J.....3610 Brooklyn Ave.
Mueller, Lawrence W...533 W. Washington Blvd.
Murdock, Harvey L. (S).417 Medical Center Bldg.

N-O

Nill, John H.....5717 S. Anthony Blvd.
Nolan, Gerald R.....5717 S. Anthony Blvd.
Oatman, Jack G.....617 Medical Center Bldg.
O'Brian, John F.....3217 Lake Ave.
O'Rourke, Carroll.....604 W. Berry St.

P

Painter, Donald S.....222 Medical Center Bldg.
Parker, Carey B.....1105 S. Harrison St.
Parrot, Donald J.....810 W. State Blvd.
Patterson, Jack W.....717 Broadway
Pauly, Leonard R.....2224 Springfield
Pearson, Huey L.....2314 S. Hanna
Perrin, Kermit F.....2701 S. Anthony Blvd.
Perry, Frederic G.....2902 Fairfield Ave.
Phelps, William J.....2828 E. State Blvd.
Pickett, Merle E.....228 Medical Center Bldg.
Popp, Milton F.....606 Medical Center Bldg.
Powell, M. Jack.....730 W. Berry St.
Priddy, Marvin E.....5010 Riviera Court

Q-R

Rank, William B.....347 W. Berry St.
Reed, John D.....3124 E. State Blvd.
Richards, Alan D.....4628 S. Calhoun St.
Rissing, Walter J.....229 W. Berry St.
Rockey, Noah A. (S).....1224 E. State Blvd.
Roser, Arthur J.....617 W. Washington Blvd.
Rossiter, Dudley L.....3629 S. Harrison St.
Rothberg, Maurice.....625 W. Berry St.
Rousseau, John W.....3124 E. State Blvd.

S

Sahlmann, Hans.....3418 S. Hanna St.
Salon, Harry W.....535 W. Berry St.
Salon, Joel W.....604 W. Wayne St.
Salon, Nathan L.....604 W. Wayne St.
Sarver, Francis E.....320 Medical Center Bldg.
Savage, Arthur R.....302 W. Berry St.
Schaab, Eric.....3714 S. Calhoun St.
Schlademan, Karl R.....520 Medical Center Bldg.
Schleinkofer, Robert M.....2828 E. State Blvd.
Schloss, Robert P.....5717 S. Anthony Blvd.
Schmidt, Eugene E.....228 Medical Center Bldg.
Schmoll, Robert J.....521 W. Wayne St.
Schneider, Louis A.....730 W. Berry St.
Schoen, Frederic L.....5717 S. Anthony Blvd.
Schoenhals, Charles E.....2818 Inwood Drive
Schubert, Jerome C.....2154 Fairfield Ave.
Scoins, William H.....1301 S. Harrison St.
Scott, H. Vaughn.....801 E. State St.
Scudder, James P.....3124 E. State Blvd.
Senseny, Eugene F.....2902 Fairfield Ave.
Shaw, James E.....3610 Brooklyn Ave.
Shinabery, Lawerence.....1850 Broadway
Short, John T. (S).....2902 Fairfield Ave.
Shugart, Robert R.....2609 Fairfield Ave.
Singer, Elmer C. (S)....310 Medical Center Bldg.
Sirlin, Edward M.....2615 Trier Rd.
Smith, C. Curtis.....3408 N. Anthony Blvd.
Smith, Philip L.....2902 Fairfield Ave.
Smith, Richard B.....3124 E. State Blvd.
Smith, Roger C.....3124 E. State Blvd.
Snyderman, Sanford C...102 Medical Center Bldg.
Somers, Gerald H.....3610 Brooklyn Ave.
Spencer, C. Herbert....519 Medical Center Bldg.
Stanley, Robert G.....3415 S. Fairfield Ave.

Stauffer, Richard C.....2730 E. State Blvd.
Steigmeyer, David J.....3124 E. State Blvd.
Stier, Paul L.....721 Broadway
Stucky, Jerry L.....5010 Riviera Court
Sullivan, Robert E.....214 Medical Center Bldg.
Swinton, Stan.....1301 S. Harrison St.

T

Taylor, Robert G.....2902 Fairfield Ave.
Tennant, David L.....1832 S. Calhoun St.
Terrill, Richard W.....446 W. Pontiac St.
Tomusk, August N.....306 Medical Center Bldg.
Towles, Jeff H.....710 E. Pontiac
Trier, Herbert P.....612 Medical Center Bldg.

U

Ungemach, Willo F.....332 Pontiac

V-W

Vogel, Lloyd A.....519 Medical Center Bldg.
Walker, Floyd B.....3505 S. Monroe
Wallace, Collins R.....234 Medical Center Bldg.
Ward, Gerald F.....3124 E. State Blvd.
Warfield, Chester H.....730 W. Berry St.
Weber, John R.....710 W. Wayne St.
Wick, Alfred A.....623 Medical Center Bldg.
Wierzalis, Edward F. .....2017 Sherman St.
Williams, Berniece M.....801 E. State Blvd.
Wilson, Roland B.....1207 S. Lafayette
Worley, Ansel C.....317 Medical Center Bldg.
Wright, William C.....621 Medical Center Bldg.
Wyatt, James L., III.....206 E. Jefferson St.

X-Y-Z

Zehr, Noah (S).....301 W. Creighton
Zweig, Elmer Sam.....344 W. Berry St.

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Harshman, Louis P. (S).....R. R. 6, Frankfort
Harvey, Harry C. (S)..Methodist Home, Franklin
Emme, Richard W.....Harlan
Harless, O. Fred.....104 Summit, Monroeville

**New Haven**

Dahling, Clemens W.....Dahling Bldg.
Dahling, Fred W.....Dahling Bldg.
Emenhiser, Donald C.....608 State St.
Hoetzer, Eldore M.....502 Henry
Sidell, James P.....630 Broadway
Stumpf, Edwin E.....716 Broadway
Wade, Reynolds W.....1018 Bell Ave.

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Miller, Kenneth D.....Woodburn

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Helmer, Frederic A.
4519 Barbara Pl., Cincinnati, Ohio 45229
Oyer, John H.....702 12th St., Huntsville, Texas
Philbert, Richard N.
2430 Edith Ave., Redwood City, Calif.
Prentiss, Nelson H...V. A. Hospital, Oteen, N. C.
Schellhouse, Earl M.
V.A. Hospital, Chillicothe, Ohio
Sherwood, Clarence E.
R. R. #2, Box 97A, Madison, S. Dakota
Voorhees, Robert J.
22 Ledyard Rd., Wellesley, Mass.

## BARTHOLOMEW-BROWN COUNTIES

**Columbus**

Able, Walter.....2760 25th St.
Adler, David L.....Bartholomew County Hospital
Andrews, Fred B.....1919 25th St.
Beggs, Lowell F.....832 Washington St.
Clay, Eleanor.....2739 Central Ave.
Daugherty, Forest D.....2600 Sandcrest Blvd.
Davis, Marvin R.....908 Washington
Dugan, Thomas.....Doctors' Park
Echsner, Herman J.....Doctors' Park
Fisher, Walter S.....422 Ninth St.
Fuller, Robert G.....1919 25th St.
Gammell, Lindley L.....602 22nd St.
Grangier, Bernard A.....2760 25th St.
Hart, Robert B.....712 Washington St.
Hauersperger, Alfred D.....2760 25th St.
Hawes, Marvin E.....522 Seventh Ave.
Henry, Alvin L.....Doctors' Park
Knotts, Halleck S.....1813 25th St.
Krueger, Robert B.....2739 Central Ave.
McCullough, Henry G...R. R. #4, Old Indpls. Rd.
Macy, George W.....2760 25th St.
Marr, Griffith.....R. R. #1
Mohler, Floyd W.....2739 Central Ave.
Norton, Harold J.....909 Pearl St.
O'Bryan, Richard B.....2739 Central Ave.
Overmire, Joseph E.....2438 Cottage Ave.
Overshiner, Lyman (S).....503 California
Ranck, Benjamin A.....2438 Cottage
Rau, Charles A.....2438 Cottage
Reid, Robert M.....2225 Central Ave.
Richmond, Harold W...Cummins Engine Co., Inc.
Ryan, William J.....Doctors' Park
Schmitt, Richard K.....423 Ninth St.
Schneider, Kenneth D.....2760 25th St.
Sigmund, William B.....2355 Central Ave.
Snapp, Richard A.....2225 Central Ave.
Teal, Dorothy D.....728 Franklin St.
Warshaw, Seymour.....2760 25th St.
Weinland, George C.....R. R. 5, Harrison Lake
Wickstrom, Otto W., Jr.....2781 National Rd.
Wickstrom, Otto W.....2779 National Rd.
Wigh, Russell.....2400 E. 17th St.
Williams, Everett W.....2225 Central Ave.
Zaring, Byron K.....718 Washington St.

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Jacobs, E. Robert
Marion County General Hosp., Indianapolis (7)
Seibel, Robert M.....Nashville

## BENTON COUNTY

Taylor, Wade H. (S).....Ambia
Leak, Robert H.....Boswell
Altier, William H.....Fowler
Miller, Dan T. (S).....Fowler
Turley, Verne L. (S).....Fowler
McKinney, Donald L.....Otterbein
Schuerich, Virgil.....Oxford
Rutherford, Charles E.
5471 W. 71st St., Indianapolis (68)

## BLACKFORD COUNTY

**(See Delaware-Blackford)**

## BOONE COUNTY

Schaaf, Alvin D.....Jamestown

**Lebanon**

Bennett, Kent B.....1720 N. Lebanon St.
Boyer, Don W.....1125 N. Lebanon St.
Coons, John D. (S)....Boone County Bank Bldg.
Coons, Ritchie.....303 W. Washington St.
Grigsby, Hardin B.....916 N. East St.
Headley, Lloyd M.....1111 N. Lebanon St.
Honan, Paul R.....1720 N. Lebanon St.
Kern, Clarence G.....1720 N. Lebanon St.
Lenox, Jack.....303 W. Washington St.
McAfee, James R.....1005 N. East St
Porter, Jack.....209 W. North St.
Weddle, Charles O.....905 N. Lebanon St.
Wiseheart, Robert H.....905 N. Lebanon St.

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Bassett, Margaret A.....Thorntown
Gregg, Edwin E.....Thorntown
Lovett, Harvey D.....Whitestown
Bailey, Lawrence S.....Zionsville
Harvey, Ralph J. (S).....Zionsville

## BROWN COUNTY

**(See Bartholomew-Brown)**

## CARROLL COUNTY

Wise, Charles L.....Camden

**Delphi**

Baker, Eldon E.....109 S. Union St.
Crampton, Charles C. (S).....115 E. Main St.
Petry, T. Neal.....111 E. Franklin St.
Seese, Robert M.....101 W. North St.
Wagoner, George W.....Front & Union Sts.

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Adams, Max R.....Flora
McLaughlin, James R.....Flora

## CASS COUNTY

Dutchess, C. Toney.....Galveston

**Logansport**

Adamski, Michael S.....408 North St.
Bailey, Earl W.....212 Fifth St.
Bean, Joseph S.....Memorial Hospital
Burnett, Paul C.....Logansport State Hosp.
Cheng, Sylvia F.....Logansport State Hosp.
Chu, Johnson C.S.....Logansport State Hosp.
Cobb, Clarence M.....Memorial Hospital
Eckert, Russell A.....1101 Michigan Ave.
Fogel, Ernest J.....Logansport State Hosp.
Gatzimos, Christos D.....3116 High Street Rd.
Glendening, Richard L.....420-A High St.
Hall, Bernard R.....422 High St.
Harrington, James F.....1001 E. Broadway
Hedde, Eugene L.....211 S. Third St.
Hillis, Lowell J.....718 E. Broadway
Hochhalter, Marian.....86 Ninth St.
Horning, Richard R.....Logansport State Hosp.
Jones, J. Carl.....422 North St.
King, Jay M.....812 North St.
Maschmeyer, Robert H.....Logansport State Hosp.
Matheu, Heracleo.....Logansport State Hosp.
Morrical, Russell J.....212 Fifth St.
Parker, E. Camille.....2500 E. Broadway
Parker, Francis W., Jr.....2500 E. Broadway
Pfuetze, Max E.....408 North St.
Phipps, Elwood B.....Logansport State Hosp.
Sheller, Tom G.....Logansport State Hosp.
TerBush, Edward L.....216 Ninth St.
Viney, Charles L.....402 North St.
Wilson, Paul H.....422 North St.
Winter, Donald K.....422 North St.

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Newcomb, William K.....Royal Center
Flanagan, Estle P. (S).....Walton
Lybrook, Daniel E. (S).....Young America

## CLARK COUNTY

**Charlestown**

Goodman, Eli.....807 High St.
Jones, David H.....935 Water St.
Marshall, Thomas J. (S).....807 High St.
Shina, Hassi .....Charlestown Landing Road

**Clarksville**

Carnes, Edwin R.....647 Eastern Blvd.
Mudd, Joseph P.....815 Eastern Blvd.
Willner, Alan.....630 Eastern Blvd.
Wolverton, George M.....647 Eastern Blvd.

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Carr, Joseph H.....Henryville
Greene, William R.....Henryville
Horlander, Fridolin.....Henryville

**Jeffersonville**

Adair, Samuel L.....201 E. Market St.
Bizer, Mier A.....1206 N. Spring St.
Brill, Joseph B.....201 E. Market St.
Bruner, Ralph W. (S).....437 Spring St.
Byrd, Ryland P.....210 Sparks Ave.
Carlberg, Dale L.....226 E. Maple St.
Carney, Joel T. (S).....347 Spring St.
Clark, William B., Jr.....435 Spring St.
Corrao, Thomas J.....435 Spring St.
Ely, Cecil W.....Clark County Hospital
Forsee, Norman E.....211 E. Market St.
Golden, W. Y.....437 Spring St.
Hargett, Herbert P.....435 Spring St.
Havens, A. Lyle.....432 Wall St.
Havens, Thomas R.....432 Wall St.
Huoni, John S...1405 Youngstown Shopping Center
Isler, Nathaniel C.....519 Spring St.
Johnson, Jerome M.....1426 Gateway Plaza
McKechnie, Robert K.....432 Wall St.
Oca, Clemente F.....220 Wall St.
Reed, Edsel S.....Clark County Hospital
Reeder, Henry H.....140 N. High St.
Roby, Alma L.....201 E. Market St.
Shaw, Houston W.....435 Spring St.
Weems, Mallory P.....203 Lindley Bldg.
Witt, William R.....Medical Center

**Sellersburg**

Regan, George L.....115 N. Indiana Ave.
Sturgis, Donald G.....Box 156

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Baldwin, J. H. (S)
1512 Spruce St., Apt. 2014, Philadelphia, Pa. 19102

## CLAY COUNTY

**Brazil**

Farid, Rahim S.....111 N. Walnut St.
Garvin, Donald B.....111 N. Walnut St.
McCormick, Wilbur C.....R. R. #2
Maurer, J. Frank.....111 N. Walnut St.
Maurer, Robert M.....111 N. Walnut St.
Mehne, Richard G.....1½ E. National Ave.
Shattuck, John C.....1½ E. National Ave.
Webster, Robert K.....28 N. Franklin St.
Wood, Opal L.....111 N. Walnut St.

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Moon, Charles E.....Center Point
Bond, Walter C.....Clay City
Buell, Forrest R.....Clay City

## CLINTON COUNTY

**Frankfort**

Applegate, Albert E.....1303 S. Jackson St.
Beardsley, Frank A. Jr.....400 Kentwood Dr.
Carrel, Francis E.....209 S. Columbia St.
Dupler, Lee F.....650 Ann St.
Dykhuizen, Theodore A.....201 W. Walnut St.
Erdel, Milton W.....2 E. White St.
Flora, Fred W.....1256 S. Jackson St.
Hammersley, George K.....361 E. Clinton St.
Hedgcock, Robert A.....259 E. Clinton St.
Stout, Harry T.....1256 S. Jackson St.
Van Kirk, Paul P.....1252 S. Jackson St.
Williams, Earl K.....Clinton County Hospital
Work, Bruce A.....306 Peoples Life Bldg.

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Bush, Charles E.....Kirklin
Carlyle, Ivan E. (S).....Michigantown
Ketcham, John S. (S).....Rossville
Weller, Ralph D.....Rossville

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Work, Bruce A., Jr.
1406 White St., Ann Arbor, Mich.
Holmes, Claude D. (S)
329 Romano St., Coral Gables, Fla.

## CRAWFORD COUNTY

(See Harrison-Crawford)

## DAVIESS-MARTIN COUNTIES

Rohrer, James R.....Elnora

**Loogootee**

Chattin, Robert E.....102 Wood
Lett, Emory B.....408 E. Main

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Sears, Don.....Odon
Pierce, William J.....724 Broadway, Vincennes

**Washington**

Barrett, James W. .....1312 Bedford Rd.
Blazey, Arthur G.....7 E. Walnut St.
Chattin, Vance J.....514 E. Main St.
Farris, John J.....514 E. Main St.
Fox, C. Philip.....305 Peoples Bank Bldg.
Lindsay, Hamlin B.....511 E. Main St.
McKittrick, Jack.....Peoples Bank Bldg.
McNaughton, Lawrence M.....400 E. Hefron St.
Norton, Horace O.....511 E. Hefron St.
Rang, Arthur A. (S).....211 N.E. Ninth St.
Rang, Robert H.....1312 Bedford Rd.
Ross, Glenn E.....1307 Bedford Rd.
Schafer, William C.....1312 Bedford Rd.
Schroeder, Henry R., Jr.....101 N.E. First St.
Seat, Marshall H.....2 E. Walnut St.

## DEARBORN-OHIO COUNTIES

**Aurora**

Baker, Leslie M.....501 Fourth St.
Gresham, Edwin L.....501 Fourth St.
Jackson, John K.....223 Mechanic St.
Olcott, Charles W.....203 Main St.
Treon, James F. (S).....505 Fifth St.

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McNeely, Matthew J.....Box 35, Dillsboro

**Lawrenceburg**

Beres, Joseph S.....370 Bielby Rd.
Bowen, Gerald T.....209 Fourth St.
Conrad, Henry W.....370 Bielby Rd.
Frable, Frank L., Jr.....370 Bielby Rd.
Houston, Fred D.....30 W. High St.
Hunter, Lowell G.....370 Bielby Rd.
Lindgren, Ivan T.....370 Bielby Rd.
Morrison, George G., Jr.....209 Fourth Ave.
Pfeifer, James M.....319 Front St.
Rhodes, Alfred K.....370 Bielby Rd.
Streck, Francis A.....326 Walnut St.
Weisenberger, Brockton L.....370 Bielby Rd.

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Fessler, Gordon S.....311 Main St., Rising Sun
Mauricio, Amado S. A. ...226 Main St., Rising Sun

## DECATUR COUNTY

Tremain, Milton A. (S).....Adams

**Greensburg**

Acher, Robert P.....221 E. Washington St.
Callaghan, Winship C.....304 Bates Bldg.
Dickson, Dale D.....333 E. First St.
Miller, James C.....205 Bates Bldg.
Morrison, James T.....207 N. Franklin St.
Overpeck, Charles.....Murphy Bldg.
Shaffer, William.....214 N. Franklin St.
Walker, Louis.....215 N. Franklin St.

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Porter, Robert A.
8211 Anentone Lane, Indianapolis (19)
Porter, Edward A. (S).....Westport

## DE KALB COUNTY

Showalter, John P.....R. R. 5, Angola

**Auburn**

Covell, Harry M.....127 W. Seventh St.
Geisinger, Lewis N. (S).....805 S. Indiana Ave.
Harvey, John C.....405 S. Main St.
Hathaway, C. Bishop.....209 N. Jackson St.
Hines, Archie V. (S).....401 S. Main St.
Hines, John H.....403 Main St.
Hippensteel, Harland V.....208 W. Seventh St.
Nugen, Harold.....223 W. Seventh St.
Rogers, Evered E.....212 W. Sixth St.
Sanders, Jesse A. (S).....1007 S. Main St.
Souder, Bonnell M. (S).....206 W. Seventh St.
Wills, Max.....347 W. Seventh St.

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Shultz, Clifford.....Butler
Weirich, Charles I.....Butler

**Garrett**

Carpenter, Ramesh S.....315 S. Randolph St.
Jinnings, Loren E.....200 S. Randolph St.
Kantzer, Floyd B.....200 S. Randolph St.
Nason, Robert A.....123 E. King St.
Novy, Charles A.....200 S. Randolph St.

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Coleman, Floyd B.....Waterloo
Graber, Benjamin R. .....Waterloo
Hughes, William B.....Waterloo

## DELAWARE-BLACKFORD COUNTIES

Brown, Stewart D.....Albany
Puterbaugh, Karl E.....Albany
Hurley, John R.....Daleville
Weisner, Richard M.....State Road 3, Eaton
Ko, Richard C. B.....Gaston

**Hartford City**

Dodds, James U.....227 W. Main St.
Dudgeon, Charles A.....720 N. Spring St.
Jackson, Dean B.....401 W. Washington St.
Owsley, Guy A.....214 N. High St.
Parks, George O.....720 N. Spring St.
Weldy, Bryce P.....227 W. Franklin St.
Werry, Leslie E. (S).....1223 N. High St.

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Doles, Ted S.....613 N. 10th St., Middletown
Egger, Ross L.....613 N. 10th St., Middletown
Burns, Paul E.....119 W. High St., Montpelier
Ingram, Richard
124 S. Washington St., Montpelier

**Muncie**

Adams, Julia L.....Ball State University
Adams, William B.....Ball Memorial Hospital
Alvey, Charles R.....217 S. Cherry St.
Ball, Clay A. (S).....303 W. Adams St.
Ball, Philip.....2600 W. Jackson St.
Benken, Lawrence D.....1111 W. Jackson St.
Bergwall, Warren L.....223 Tillotson Ave.
Bibler, Henry E.....311 W. Adams St.
Botkin, Charles L. (S).....508 W. Jackson St.
Botkin, Charles T.....400 White River Blvd.
Botkin, Clyde G.....508 W. Jackson St.
Brown, Leland G.....412 White River Blvd.
Brown, Thomas M.....212 N. Pauline Ave.
Burwell, Stanley W.....424 W. Jackson St.
Butterfield, Robert M.....315 W. Jackson St.
Butz, Ralph O.....1525 W. Jackson St.
Clark, Lintner E. .....420 W. Washington St.
Clark, Robert M.....2809 Godman Ave.
Cochran, Robert B.....1111 W. Jackson St.
Collins, Margaret C.....Ball Memorial Hospital
Cooper, John F.....3022 S. Madison
Covalt, Wendell E.....2724 W. North St.
Cullison, John L.....2724 W. North St.
Cure, Elmer T.....122 W. Jackson St.
David, George J.....2200 Janney Ave.
Davis, Edgar C. (S) ....203 Western Reserve Bldg.

Deutsch, William.....406 White River Blvd.
Dietz, David J.....321 University Ave.
Dunning, Thomas W.....400½ White River Blvd.
Dutchman, William R.....Ball Memorial Hospital
Fiederlein, Frederick J.....2809 Godman Ave.
Galliher, Marjorie J.....410 White River Blvd.
Garling, Luvern C.....521 S. Tillotson Ave.
Geckler, Charles E.....203 Western Reserve Bldg.
Gibson, Robert K.....806 W. Jackson St.
Gill, Thomas A.....808 W. Jackson St.
Greiber, Marvin F.....420 W. Washington St.
Gustafson, Milton H.....2606 W. Jackson St.
Hall, Robert S.....1604 W. McGallaird
Harvey, Emerson C., Jr.
Delco Battery Operations
Hayes, Theodore R.....210 S. High St.
Henderson, Ramon A.....806 W. Jackson St.
High, Ralph L.....420 W. Washington St.
Holmes, John L.....412 White River Blvd.
Hostetter, Irwin S.....115 N. Cherry St.
Imhof, Joseph D.....318 W. Adams St.
Judd, Donald R.....100 N. Cherry St.
Kalker, Morton.....Ball Memorial Hospital
Kammer, Grace C.....1005 W. Parkway Dr.
Kammer, Walter F.....420 W. Washington St.
Kim, Joon S.....Ball Memorial Hospital
Kirshman, Forrest E.....211 S. High St.
Koch, Edwin F., Jr.....Ball Memorial Hospital
Koss, K. William.....1600 W. Jackson St.
Kress, James W.....2809 Godman Ave.
LaDuron, Jules F. (S).....614 S. Liberty St.
Lawson, Lawrence J.....321 University Ave.
McCallister, Larry L.....2518 Rosewood
McClintock, James A.....316 W. Adams St.
McDowell, Fletcher W.....926 W. Main St.
Mathewson, Russell C.....553 Johnson Bldg.
Montgomery, Lall G.....Ball Memorial Hospital
Montgomery, Ralph F.....2809 Godman Ave.
Moore, Jack C.....212 N. Pauline Ave.
Moore, Thomas C.....110 N. Cherry St.
Moore, William C. (S).....110 N. Cherry St.
Morris, Jean W.....247 Johnson Bldg.
Neece, Gus W.....Ball State University
Nelson, Harold E.....424 W. Jackson St.
Newnam, Philip E.....420 W. Washington St.
Osborne, John V.....420 W. Washington St.
Peacock, Robert C.....2724 W. North St.
Pippenger, Joseph I.....310 W. Jackson St.
Pippenger, Wayne G.....Ball State University
Quick, William J.....314 E. Washington St.
Rivers, Glynn A.....625 W. Adams St.
Schulhof, Maurice G.....420 W. Washington St.
Searight, Howard R.....402 W. Jackson St.
Smith, James S.....501 Kirby Ave.
Speck, Carlson R.....Ball Memorial Hospital
Stanley, John R.....1111 W. Jackson St.
Steele, Frank M.....420 W. Washington St.
Stibbins, Warren E.....2605 Wheeling Ave.
Stout, Francis E.....2423 W. Jackson St.
Stump, Richard L.....2000 S. Madison
Taylor, Donald R.....Ball Memorial Hospital
Tharp, Donald W.....1517 N. Tillotson Ave.
Tomlin, Hugh M.....420 W. Washington St.
Vlaskamp, Elaine M.....401 W. Main St.
Voss, Gert.....420 W. Washington St.
Walker, Jack M.....412 White River Blvd.
Ware, Herbert E.....2200 Janney Ave.
Wince, Leland L.....806 W. Jackson St.
Young, Gerald S.....924 W. Main St.

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Hinchman, Jean F.....Parker
Hill, Robert E.....Yorktown
Moss, Mavor J.....Yorktown

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Clouse, John F.....Armed Forces Examination Sta., 312 E. Fifth St., Amarillo, Texas
Morse, Arthur S.
10332 Shadow Oaks Dr., Houston, Texas
Venis, Kemper N.....General Delivery, Los Angeles, Calif.

## DUBOIS COUNTY

Barrow, John H.....Dale
Backer, Henry G.....Ferdinand
Erhart, Hubert.....Ferdinand
Bland, Jack D.....Holland

### Huntingburg

Bretz, John M.....302 Fourth St.
Craig, Harry L.....409 Van Buren
Scales, Alfred B.....407 Van Buren
Scales, Allen D.....409 Van Buren
Stork, Harvey K.....530 Fourth St.
Williams, Fielding P.....215 W. Walnut St.

### Jasper

Beaven, John B.....111 Central Bldg.
Benages, Anthony.....948 MacArthur St.
Gootee, Francis H.....501 Clay St.
Gootee, Thomas H.....501 Clay St.
Heck, Martin C.....801 Newton
Held, George A.....716 W. Ninth St.
Klamer, Charles H.....715 MacArthur St.
Lukemeyer, St. John.....109 W. 12th St.
Ploetner, Edward J.....201 W. Sixth St.
Salb, John P.....106 Metzger Bldg.
Salb, Leo A. (S).....301 E. Sixth St.
Wagner, Arthur L.....115 E. Ninth St.

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Amini, Sohrab...1703 Spruce Lane, Louisville, Ky.
Ozalan, Necmettin H.....46 Fair Harbor Place, New London, Conn.

## ELKHART COUNTY

Horswell, Richard G.....Bristol
Neidballa, Edward G.....Bristol

### Elkhart

Arlook, Theodore D.....912 Franklin St.
Atwood, William H.....405 S. Second St.
Bender, Robert L.....411 S. Third St.
Benson, James E.....405 S. Second St.
Billings, Elmer R.....405 S. Second St.
Bloom, George R.....506 S. Second St.
Boling, Richard C.....214 W. Marion St.
Bowdoin, George E. (S).....515 S. Second St.
Campbell, Patrick B.....605 Oakland Ave.
Classen, Pete R. C.....4112 S. Main St.
Compton, Walter A.....2225 Greenleaf Blvd.
Conklin, Raymond L...Miles-Ames Research Labs.
Cormican, Herbert L.....1400 Hudson St.
Dovey, Edward G.....513 Oakland Ave.
Durham, Thomas E.....405 S. Second St.
Echeverria, Rodolfo E.....405 S. Second St.
Elliott, Thomas A.....405 S. Second St.
Finfrock, James D.....608 West Blvd.
Futterknecht, James O.....405 S. Second St.
Gattman, George B.....405 S. Second St.
Graber, Virgil R.....1400 Hudson St.
Gray, Edwin H.....518 W. Franklin St.
Gray, Mary Case.....518 W. Franklin St.
Hannah, Jack W.....1906 E. Jackson Blvd.
Heminway, Norman L.
Miles-Ames Research Labs.
Hurley, James W.....405 S. Second St.
Ivy, John H.....405 S. Second St.
Keating, John U.....224 W. High St.
Kesim, Mufit H.....317 W. Lusher Ave.
Kielton, Melvyn J.....319 W. Lusher Ave.
Kintner, Burton E.....506 S. Second St.
Kistner, Arthur W.....400 Equity Bldg.
Klassen, Otto D.....2600 Oakland Ave.
Koehler, Elmer G.....416 W. Lexington Ave.
Krause, Frederick.....4117 S. Main St.
Lundt, Milo O.....521 S. Second St.
Luther, William C.....Ames Company, Inc.
McArt, Bruce A.....221 W. Jefferson

Mark, George A.....413 W. Franklin St.
Martin, Paul H.....313 N. Second St.
Middleton, Ramona J.....1400 Hudson St.
Miller, Donald G.....4634 W. Indiana Ave.
Miller, Galen R.....403 S. Ninth St.
Miller, Hugh A., Jr.....1127 Myrtle St.
Miller, Samuel T. (S).....506 S. Second St.
Mininger, Edward P.....1400 Hudson St.
Mishkin, Irving.....209 S. Second St.
Norris, Allen A. (S).....401 W. Marion St.
Paff, William A.....115 S. Third St.
Paine, George E.....329 Meisner Ave.
Pancost, Vernon K.....1000 W. Marion St.
Parshall, Dale B.....3528 Gordon Rd.
Pletcher, William D.....405 S. Second St.
Rouen, Robert L.....114 Monger Bldg.
Rupe, Lloyd O.....211 S. Fifth St.
Rupel, Dennis F.....2600 Oakland Ave.
Scheer, Alexander L.....405 S. Second St.
Schlosser, Herbert C. (S).....116 W. Marion St.
Sears, Murray M. (S).....304 Equity Bldg.
Silber, David L., Jr.....405 S. Second St.
Spray, Page E.....320 W. High St.
Stauffer, Walter A. (S).....701 Strong Ave.
Stubbins, William M.....1006 W. Franklin St.
Swank, Lucretia R.....1600 E. Jackson Blvd.
Swihart, Danny D.....506 S. Second St.
Swihart, Homer R.....1200 W. Marion St.
Wilson, Orley E.....217 N. Main St.
Work, James A., Jr. (S).....406 S. Second St.
Yoder, C. Richard.....603 Oakland Ave.

**Goshen**

Amstutz, H. Clair.....2711 S. Main St.
Bender, John M.....112 W. High Park Ave.
Bigler, Frederick W.....214 S. Fifth St.
Bowser, Philip G.....107 S. Fifth St.
Chandler, Leon H.....112 E. Lincoln Ave.
Gunderson, Shaun D.....Goshen General Hospital
Harris, Neil R.....307 S. Seventh St.
Hostetler, Carl M.....304 E. Lincoln Ave.
Kennedy, Myron S.....314 S. Fifth St.
Krabill, Willard S.....110 W. High Park Ave.
Martin, Floyd S.....127 E. Lincoln St.
Quilty, Thomas J.....112 E. Madison St.
Simmons, Lloyd H. (S).....208 E. Lincoln Ave.
Smucker, Ernest E.....112 S. Fifth St.
Troyer, Dana O.....122 E. Clinton St.
Troyer, George W.....110 W. High Park Ave.
Turner, John P.....115 E. Washington St.
Wagner, David G.....307 S. Seventh St.
Young, Ralph H.....113 E. Madison St.

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Teters, Melvin S. (S).....Middlebury
Yoder, Jonathan G.....Middlebury
Rheinheimer, Floyd L.....Milford
Massanari, Walter S.....Millersburg

**Nappanee**

Kendall, Forest M.....219 W. Market St.
Price, Douglas W.....162 E. Market St.
Roose, Lisle W.....357 N. Nappanee St.
Wenger, James E.....357 N. Nappanee St.

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DeFries, John J.....New Paris

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Clark, Jack P.....303 S. Hunnington, Syracuse
Craig, Robert A.....P. O. Box 607, Syracuse
Fosbrink, Ephraim L...107 W. Main St., Syracuse
Zimmerman, William H.....R. R. No. 2, Syracuse

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Guttman, John B.....Wakarusa
Miller, James.....Wakarusa
Mendez, Carlos..Beatty Memorial Hosp., Westville

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Todd, David D. (S)
5835 Beaumont Ave., La Jolla, Calif.

## FAYETTE-FRANKLIN COUNTIES

**Brookville**

Foreman, Walter A.....617 Main St.
Peters, Elmer E.....830 Main St.
Seal, Perry F.....901 Main St.
Smith, Herbert N.....812 Main St.

**Connersville**

Dale, Maxwell H.....818 Grand Ave.
Ellis, George M.....108 E. 10th St.
Gregg, Albert F.....124 E. Sixth St.
Hudson, Arlington M.....321 W. 20th St.
Kerrigan, William F.....718 Central Ave.
Lockhart, Jack M.....707 W. Third St.
Mountain, Francis B.....930 Central Ave.
Neukamp, Frank H.....707 W. Third St.
Sanders, Bertram W.....930 Central Ave.
Steinem, Joseph L.....812 Grand Ave.
Watterson, Gerald T.....1910 Virginia Ave.
Winklepleck, A. M.....R. R. #6

## FLOYD COUNTY

**New Albany**

Baker, Avey M. (S).....811 E. Spring St.
Baxter, Samuel M.....1201 E. Spring St.
Bickers, Everett E.....3541 Paoli Pike
Brown, Kenneth H.....410 E. Spring St.
Buchman, Marshall H.....1824 State St.
Cannon, Daniel H.....1203 E. Spring St.
Cook, Melvin D.....919 E. Spring St.
Edwards, William F.....604 E. Spring St.
Garner, William H., Jr.....919 E. Spring St.
Garner, William H., Sr. (S).....919 E. Spring St.
Gentile, John P.....101 Adams St.
Geyer, Joseph H.....Southern Indiana Tuberculosis Hosp.
Harris, Leo C.
Southern Indiana Tuberculosis Hosp.
Hess, Paul P.....Floyd Co. Bank Bldg.
Higgins, John R.....700 E. Spring St.
LaFollette, Donald R.....1000 E. Spring St.
LaFollette, Robert E.....1000 E. Spring St.
McCullough, James Y.....700 E. Spring St.
Nedelkoff, Bogdan.....R. R. 2, Box 500H
Paris, John M.....602 E. Spring St.
Pierce, Gene S.....1696 Garretson Lane
Robertson, Addis N. (S).....820 E. Spring St.
Robinson, Nan.....1726 State St.
Ruoff, William F.....1109 Lafayette Dr.
Shelton, Clyde F.....1726 State St.
Sonne, Irvin H., Jr.....1850 State St.
Streepey, Jefferson I.....1102 E. Spring St.
Tyler, Frank T. (S).....Hausfeldt Lane
Voyles, Harry E.....213 Elsby Bldg.
Wallace, Elmer L.....1516 State St.
Wolfe, Morton F.....2533 Glenwood Ct.
Wolfe, Nelson A.....1117 E. Spring St.
Worley, Henry L.....601 E. Spring St.
Youngs, Paul E.....2652 Charlestown Rd.

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Allen, George S.....Georgetown
Byrn, Howard W. (S).....Oxford
Sloan, Herbert P....Lincoln Heights, Jeffersonville

## FOUNTAIN-WARREN COUNTIES

**Attica**

Fisher, John E.....217 S. Perry St.
Maris, Lee J.....201 Brady St.
Petrich, Peter R.....401 S. Perry St.
Raymundo, Vivencio F.....401 S. Perry St.
Ringer, William A.....401 S. Perry St.

**Covington**

Hoffman, Max N.....416 Union St.
Humphrey, Edward M.....Olin Mathieson Corp.
Stephens, Lowell R.....600 E. Liberty St.

Suzuki, Tsutomu T.....505 Washington St.

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Furr, Jack D.....Kingman
Smith, Byron J.....Kingman
Person, Theodore C.....Veedersburg
Rusk, Hubert M.....Wallace
Nelson, Carl A.....West Lebanon
Crain, James W.....Williamsport

## FULTON COUNTY

Herrick, Charles L.....Akron
Miller, Virgil C.....Akron
Kraning, Kenneth K.....Kewanna

### Rochester

Herendeen, Elbie V.....120 W. Ninth St.
Knockel, Wayne L.....819 E. Ninth St.
Richardson, Charles L.....121 W. Eighth St.
Richardson, Joseph D.....121 W. Eighth St.
Rowe, Howard H.....720 Jefferson St.
Rusler, William J.....817 E. Ninth St.
Stinson, Dean K.....816 Main St.

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Kelsey, Lawrence E.....102 W. Keim Dr., Phoenix, Ariz.

## GIBSON COUNTY

Geick, Raymond G.....Fort Branch
Marchand, Edwin V.....Haubstadt
Petitjean, Harold G.....Haubstadt
Dye, William E.....Oakland City
Ropp, Eldon R. (S).....Oakland City

### Princeton

Folck, John K.....115 N. Prince St.
Graves, Orville M. (S).....116 S. Hart St.
McCarty, Virgil.....113 S. Main St.
McElroy, Robert S.....116 S. Main St.
Noveroske, Richard J.....Gibson General Hospital
Peck, James F.....218 Broadway
Weitzel, Roland E.....114 S. Hart St.
Wells, William R.....109 E. State St.

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Brazelton, O. T. (S)
13601 Cedar Crest Lane, Apt. 100-G, Seal Beach, Calif.

## GRANT COUNTY

Breedlove, C. Dane.....Fairmount
Yale, Charles A.....Fairmount
Garrison, Leon J..... 114 S. First St., Gas City
Koontz, William A.....126 E. Main St., Gas City
Shoemaker, Richard L...604 N. Third St., Gas City
Rhamy, Donald 8448 Spring Mill Ct., Indianapolis
Baskett, Russell J.....Jonesboro

### Marion

Abell, Charles F.....500 Wabash Ave.
Alderfer, Henry H.....131 N. Washington St.
Ansbacher, Stefan (H).....Fox Station Rd. W.
Ayres, Wendell W.....500 Wabash Ave.
Bailey, Douglas A.....1251 Kem Rd.
Bloom, Asa W.....724 W. Third St.
Boyer, Grace M. B.....605 Locust St.
Brown, Robert M....520 Marion Nat'l Bank Bldg.
Comeau, William J.....Marion General Hosp.
Cunningham, Robert D.....500 Wabash Ave.
Davis, Joseph B.....131 N. Washington St.
Davis, Merrill S. (S).....131 N. Washington St.
Davis, Richard M.....131 N. Washington St.
Donaldson, Miles W.....2927 S. Washington St.
Dunbar, Fred E.....1251 Kem Rd.
Fisher, Henry.....1502 S. Washington St.
Fuelling, James L.....131 N. Washington St.
Ganz, Max.....930 S. Adams St.
Goldsmith, David A.....2711 River Rd.
Grant, M. Arthur.....P. O. Box 989
Hover, Galen M.....Veterans Hospital
Hummel, Russel M.....500 Wabash Ave.
Jarrett, John C.....131 N. Washington St.
Lahr, Richard E.....1121 W. Third St.
Langrall, Harrison M., Jr...131 N. Washington St.
Larzelere, Henry B.....131 N. Washington St.
Lavengood, Russell W.....225 Glass Block
Long, Max R.....803 S. Boots St.
Lonngren, Dudley H.....131 N. Washington St.
Love, V. Logan.....131 N. Washington St.
McKeever, Joseph W.....131 N. Washington St.
Miller, H. Allison.....320 Glass Block
Pattison, John D.....131 N. Washington St.
Pearcy, Marcene.....500 Wabash Ave.
Powell, J. Paxton.....500 Wabash Ave.
Reid, James D.....500 Wabash Ave.
Renbarger, Lester L.....1531 W. Second
Rhamy, Arthur P.....500 Wabash Ave.
Rhorer, John G.....500 Wabash Ave.
Richardson, Joseph H.....131 N. Washington St.
Schroeder, Robert W.....317 N. Western Ave.
Simmons, Frederick H.....1009 N. Baldwin
Skomp, Claud E.....500 Wabash Ave.
Smith, Barton T.....131 N. Washington St.
Snowhite, Arthur B.....500 Wabash Ave.
Thompson, B. Jay.....Marion General Hosp.
Thompson, John R.....1251 Kem Rd.
Walton, R. Lee.....131 N. Washington St.
Warren, Carroll B.....511 Glass Block
Watkins, James K.....131 N. Washington St.
Weinberg, Samuel.....104 W. Third St.
Wilson, Ned A.....317 N. Western Ave.
Wojcik, Ladislas D.....131 N. Washington St.
Woodbury, John W.....131 N. Washington St.
Young, Robert G.....1207 Northwood Ct.

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Beck, Thomas A.....Swayzee
Taylor, Everett C.....Upland
Rifner, Eugene S.....Van Buren
McIlwain, Eleanor E....Methodist Home, Warren
McIlwain, Robert E. ....Methodist Home, Warren

## GREENE COUNTY

### Bloomfield

Graf, Jerome A.....6 E. Main St.
Mount, Mathias S.....55 N. Franklin St.
Turner, Harold B. (S).....126 E. Indiana Ave.
Turner, Jack J.....126 E. Indiana Ave.
Van Sandt, Frank A. (S).....110½ E. Main St.

### Jasonville

Porter, Carl M.....124 Cook St.
Rotman, Harry G.....111½ E. Main St.
Rotman, Sam I.....P. O. Box 127

### Linton

Bailey, Edwin B.....129 E. Vincennes
Broshears, Kenneth P.....129 E. Vincennes
Raney, Ben B.....129 E. Vincennes
Tomak, Milton E.....289 N. Main St.
Woner, John W.....Linton

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Hamilton, M. Luther (S).....Newberry
Moses, George E.....Worthington
Moses, Robert E.....Worthington

## HAMILTON COUNTY

Karlick, Joseph R.....Arcadia
McDaniel, Franklin P. (S).....Atlanta
Donahue, Claude M.....Carmel
Thomas, W. Clayton.....Carmel
Havens, Oscar.....Cicero
Ayers, Marion E.....10447 College Ave., Indianapolis (80)

**Noblesville**

Ambrose, Jesse C.....298 N. Ninth Street
Blackburn, Howard R.....Riverview Hospital
Campbell, Sam W.....88 S. 19th St.
Carter, Eunice M.....1084 Clinton St.
Harris, Robert F.....120 N. Ninth St.
Hash, John S.....110 Lakeview
Haywood, John G.....120 N. 11th St.
Kraft, Haldon.....195 S. 10th St.
Lanning, R. Adrian.....10th and North Dr.
Lloyd, Joe R.....107 John St.
Shanks, Ray W.....1507 Logan St.
Southard, Carl B.....55 S. 16th St.

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Griffith, James W.....Sheridan
Manhart, Doyle B.....Sheridan
Newby, Eugene .....Sheridan
Waitt, Paul.....Sheridan
Connoy, Andrew F.....Westfield
Connoy, Leo F.....Westfield

## HANCOCK COUNTY

Scott, Robert O.....Charlottesville
Garrison, James L.....Cumberland
Navin, Hugh K.....Fortville
Rhynearson, Hal R..... Fortville

**Greenfield**

Beeson, Wilbur P.....1001 N. State St.
Endicott, Wayne H. ..... 10 W. Boyd St.
Farrell, John J., Jr.....1001 N. State St.
Henn, R. Anthony.....137 Michigan St.
Hunter, Donn R.....10 W. Boyd St.
Kinneman, Robert E.....114 N. State St.
Kirby, Ted C.....1001 N. State St.
Moenning, John E.....114 N. State St.
Rea, Ralph L.....114 N. State St.
Smith, John H.....114 N. State St.
Vingis, Bronie A.....746 N. State St.

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Cagle, Bob R.....New Palestine
Pierson, Thomas A.....New Palestine
Freeborn, Warren S., Jr.....Oaklandon
Miller, Joseph A.....Oaklandon
Gibbs, Charles M. (S)..Methodist Home, Warren
Kuhn, Robert W.....Wilkinson

## HARRISON-CRAWFORD COUNTIES

**Corydon**

Blessinger, Louis H.....101 W. Chestnut St.
Brockman, Wilfred J.....439 E. Chestnut
Dillman, Carl E.....Beaver & Oak Sts.
Dukes, David J.....439 E. Chestnut St.
Jordan, Richard A.....Harrison Dr.
Martin, Samuel W.....R.R. 1

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Baker, Guy D. (S).....Crandall
Gobbel, Novy E. (S).....English
Seipel, Stanley.....Lanesville
Benz, Jesse C. (S).....Marengo

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Mathys, Alfred (S).....234 E. Walnut St.,
Louisville, Ky.

## HENDRICKS COUNTY

**Brownsburg**

Black, M. James.....702 E. Main St.
Foltz, Lloyd E.....20 W. Main St.
Scudder, Arthur N.....24 N. Grant St.
Walker, Thomas M.....702 E. Main St.

**Danville**

Cheesman, Donald D.....637 E. Main St.
Frantz, Mount E.
% Fred Shelton, Danville State Bank
Heinlein, Carl L.....637 E. Main St.
Kirtley, Robert W.....138 W. Marion St.
Koch, Elmer L.....201 E. Columbia St.
Southard, James E.....985 W. Main St.
Terry, Lloyd S.....138 W. Marion St.
Chase, Thomas P.
Avon, Box 300C, R. R. 8, Indianapolis
Ellis, Lyman H.....Lizton
Gibbs, Joseph W.
Home Lawn Sanitarium, Martinsville
Karpel, Bernard.....Mooresville
Wiseheart, Oscar H. (S).....North Salem
Scamahorn, Malcolm O.....Pittsboro

**Plainfield**

Aiken, Milo M.....140 N. Center St.
Cohen, Irving.....645 E. Main St.
Haggard, David B.....P. O. Box 191
Stafford, William C.....107 W. Main St.
Warbinton, Fred P.....P. O. Box 337

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Dalton, Naomi L.....E. T. C. M.
Hospital, Kolar Mysore State, India

## HENRY COUNTY

Clark, Marion E.....Cambridge City
Donahue, Francis E.....Dublin
Hollenberg, Alfred E.
700 N. Washington St., Hagerstown
Miller, William A..99 S. Washington, Hagerstown
Wiatt, Leonard H.....Knightstown
Stauffer, George E.....Mooreland

**New Castle**

Amos, Robert L.....540 S. Main St.
Bledsoe, James G.....319 S. 14th St.
Brock, Joseph T.....New Castle State Hosp.
Burnett, Arthur B.....106 N. Main St.
Cain, David R.....1912 Bundy Ave.
Das, Amal K.....New Castle State Hosp.
Dye, Cloyd L.....1007 N. 16th St.
Easter, James N.....1912 Bundy Ave.
Fisher, John E.....540 S. Main St.
Foster, Ray T.....420 N. Main St.
Grant, Phyllis A.....1912 Bundy Ave.
Harrison, Benjamin L.....540 S. Main St.
Heilman, William C., Jr.....1007 N. 16th St.
Heilman, William C. (S).....1007 N. 16th St.
Hill, Kenneth G.....530 S. Main St.
Iterman, George E. (S).....1007 N. 16th St.
Kennedy, Walter U. (S).....208 Union Block
Life, Homer L.....1015 Broad St.
McDonald, Frank C.....365 Parkside Dr.
McElroy, James S.....1007 N. 16th St.
McKee, Roy G.....606 N. Fair Oaks Dr.
Murray, William E.....New Castle State Hosp.
Rhee, Sang K.....2805 Hillcrest Dr.
Saint, William K.....540-B S. Main St.
Smith, Mark E.....1007 N. 16th St.
Steussy, Calvin N.....Henry Co. Hospital
Stricker, Paul J.....319 S. 14th St.
Thorne, Charles E.....200 N. 12th St.
Vivian, Donald E.....Henry County Hospital
Wilhelm, Guido P.....1007 N. 16th St.

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Robertson, William S.....Spiceland
Balcom, Francis H.....235 W. Orangewood Ave.,
#16-A, Anaheim, Calif.

## HOWARD COUNTY

Denton, Larkin D.....Greentown
Shoup, Homer B. (S).....Greentown

**Kokomo**

Althoff, William R.....Chrysler Corporation
Alward, John H.....321 W. Walnut St.
Artis, Myrle E.....519½ N. Main St.
Ault, Carl H.....502 S. Berkley Rd.
Belding, Ray T.....406 Southway Blvd., East
Blaisdell, Glenn D..... Delco Radio Div.
Boughman, Joe D.....2008 W. Sycamore
Bowers, Copeland C.....210 W. Mulberry St.
Bowers, Garvey B.....210 W. Mulberry St.
Bowers, John A.....210 W. Mulberry St.
Bradley, Richard V.....2804 S. Washington
Bruegge, Theodore J.....315 S. Berkley Rd.
Cattell, Lee M.....402 S. Berkley Rd.
Clarke, Elton R. (S).....4320 W. Sycamore Lane
Conley, Thomas M.....500 Southway Blvd., East
Craig, Reuben A. (S).....514 W. Superior St.
Craig, Reuben.....514 W. Superior St.
Crawford, Theodore R.....2114 W. Sycamore St.
DeBrota, John, Jr.....3114 Orleans Ct.
Earl, Max M..... 502 S. Berkley Rd.
Elleman, John H.....416 W. Mulberry St.
Ericson, Homer S.....107 S. Dixon Rd.
Farrell, Thomas E.....Howard Community Hosp.
Ferry, Paul W. (S).....406 Union Bank Bldg.
Fields, Donald L.....500 Southway Blvd., East
Frazier, John L.....506 Southway Blvd., East
Fretz, Richard C.....215 W. Superior St.
Golper, Marvin N.....1907 W. Sycamore St.
Good, Richard P.....400 S. Berkley Rd.
Grothouse, Carl B.....402 S. Berkley Rd.
Guin, Jere D.....522 Armstrong-Landon Bldg.
Halfast, Richard W..... 402 S. Berkley Rd.
Harshman, James A.....St. Joseph Hospital
Hoyt, John M.....3501 Hawthorne Lane
Hutto, William H.....215 W. Superior St.
Jewell, George M....610 Armstrong-Landon Bldg.
Kremers, George A.....404 S. Berkley Rd.
Lehman, David P.....2804 S. Washington
Longshore, Robert E.....2016 W. Sycamore St.
McClure, Warren N.....319 S. Berkley Rd.
McIndoo, Ralph E. (S).....313 W. Taylor St.
Mendelson, Stanley M.....401 E. Reynolds Dr.
Moore, John M.....3520 S. Lafountain
Morrison, William R. (S)..504 Union Bank Bldg.
Murray, Ernest C.....408 W. Mulberry St.
Paris, Durward W...614 Armstrong-Landon Bldg.
Perkins, Powell L.....317 S. Berkley Rd.
Phares, Robert W.....1712 S. Malfalfa Rd.
Prather, Philip E.....909 S. Courtland
Radpour, Shokri.....315 S. Berkley Rd.
Ramey, John W. (S).....107½ S. Union St.
Rhorer, Herbert M. (S).....417 W. Sycamore St.
Rinehart, James J.....401 E. Reynolds Dr.
Rudicel, Max.....1907 W. Sycamore St.
Schwartz, Frederick C.....2016 W. Sycamore
Smith, Charles F.....Howard Community Hosp.
Smith, Gloster J.....102½ S. Main St.
Spangler, Jesse S.....215 E. Taylor St.
Townley, Normand T.....2804 S. Washington St.
Trimble, John G.....116 S. Buckeye St.
Wachob, Tom W., Jr.....3520 S. Lafountain
Wible, James H.....317 S. Berkley Rd.
Wilson, Norman K.....2804 S. Washington

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Ware, John R.....Russiaville

## HUNTINGTON COUNTY

**Huntington**

Brubaker, Harold S.....42 W. Park Dr.
Casey, Stanley M.....408 E. Market St.
Clark, Joseph H.....818 W. Park Dr.
Clunie, William A.....323 W. Park Dr.
Cope, Stanton E.....1022 N. Jefferson St.
Doermann, Paul E. ..... 340 E. Market St.
Erehart, Mark G. (S)..Maple Grove Rd., R. R. 8
Eviston, John B. (S).....34 E. Washington St.
Gill, D. Richard.....1751 N. Jefferson St.
Grayston, Wallace S. (S).....303 E. Market St.
James, Thomas, Jr.....202 U. B. Publishing Bldg.
Johnston, Robert G. (S).....339 E. Market St.
Marks, Howard H.....248 W. Park Dr.
Meiser, Robert D.....612 N. Jefferson St.
Miller, Wayne S.....610 N. Jefferson St.
Peare, Reeve B.....1751 N. Jefferson St.
Van Campen, Warren M.....3 Park Moor Dr.
Wagner, Richard.....1355 Guilford
Wheeler, Barth E.....722 N. Jefferson

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Kinzer, LeRoy D.....Markle
Miller, Gerald L.....Markle
Cooper, B. Trent.....Roanoke
Bennett, J. B.....Warren
Ray, Carl S.....Warren

## JACKSON-JENNINGS COUNTIES

Gillespie, Garland R.....Brownstown
Shields, Jack E.....Brownstown
Guthrie, William H.
Muscatatuck State School, Butlerville
Knotts, Slater.....R. R. 3, Columbus
Adair, William K. (S)
115 Armstrong, Crothersville
Bard, Frank B...305 E. Howard St., Crothersville
Butler, Joe B.....508 E. Moore St., Crothersville
Scharbrough, William D.....Ewing

**North Vernon**

Berkshire, Shaffer B.....Long St.
Calli, Louis J.....408 S. State St.
Ellis, Forrest D.....241 Norris Ave.
Johnson, William A.....245 Norris Ave.
Thayer, Benet W.....20 Jackson St.

**Seymour**

Baxter, Harry R.....326 N. Walnut St.
Black, Joe M.....502 W. Second St.
Bobb, Kenneth E.....410 S. Chestnut St.
Bosch, Ralph.....635 W. Second St.
Day, William D. C.....410 S. Chestnut St.
Graessle, Harold P. (S).....304 W. Second St.
Miller, Harold E.....Vehslage Bldg.
Osterman, Louis H. (S).....901 Garden Ave.
Ripley, John W..... 321 Bruce St.
Templeton, Ian S..... 207 N. Pine St.
Wiethoff, Clifford A.....214 N. Walnut St.

## JASPER COUNTY

Schantz, Richard.....Remington

**Rensselaer**

Beaver, Ernest R.....111 Thompson St.
Greene, Robert W.....116 N. Cullen
Jones, Edwin F..... Jasper County Hosp.
O'Brien, Francis E. McKinley and Washington Sts.
Ockerman, Kenneth R.....119 W. Harrison St.
Williams, Paul A.....119 W. Harrison St.

## JAY COUNTY

**Dunkirk**

Entner, Charles L.....125 E. Commerce
Shroyer, Herbert L.....244½ S. Main St.
Tate, Elizabeth..... 317 S. Main St.

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Andrews, C. Franklin.....R. R. 1, Geneva

**Portland**

Cripe, William H. .....302 N. Meridian St.
Donnally, George A.....Jay County Hospital
Fitzpatrick, James S.....603 W. Arch St.
Gillum, Eugene M.....522 W. Arch St.
Keeling, Forrest E.....504 W. Arch St.

Lopez, Alfonso.....16 Weiler Bldg.
Lyon, Florence M.....127 E. North St.
Schenck, Ralph E.....603 W. Arch St.
Spahr, Donald E.....615 W. Race St.
Steffy, Ralph M.....504 W. Arch St.
Vormohr, Joseph F.....604 W. Arch St.

## JEFFERSON-SWITZERLAND COUNTIES

### Madison

Alcorn, Merritt O.....R. R. 2
Bryan, Paul E.....Madison State Hospital
Childs, Wallace E.....112 Presbyterian Ave.
Davis, Lloyd H. (S).....Madison State Hospital
Fong, Theodore C. C.....Madison State Hospital
Haney, William K...P. O. Box 846, Madison Station
Hare, Francis W., Jr.....722 W. Main St.
Harris, George F.....445 Clifty Dr.
Jackson, Howard C.....104 E. Third St.
Jolly, Lewis E.....722 W. Main St.
Johnson, Robert D.....722 W. Main St.
Karnafel, Eugene T.....2300 Ross St.
Libbert, Edwin L., Jr.....Madison State Hospital
McAtee, Ott B.....Madison State Hospital
Modisett, Jackson W.....722 W. Main St.
Modisett, Marcella S.....722 W. Main St.
Pratt, Ralph M., Jr.....323 Poplar St.
Riley, Henry S.....722 W. Main St.
Rucker, Warren R.....426 E. Main St.
Shuck, William A.....Odd Fellows Bldg.
Sloan, W. Keith.....426 E. Main St.
Turner, Anna Goss.....602 E. Second St.
Turner, Oscar A. (S).....602 E. Second St.
Wolf, Ava H.....Madison State Hospital
Wolf, Ray H.....Madison State Hospital
Zink, Robert O.....722 W. Main St.

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Graves, Noel S.....Vevay
Hamilton, Antha A.....Vevay

## JOHNSON COUNTY

Thomas L. McConnell.....Edinburg

### Franklin

Andrews, Hugh K.....176 E. Jefferson St.
Bullers, Robert C.....395 S. Home Ave.
Chappel, Alfred T.....100 N. Main St.
Deppe, Charles F.....301 E. Jefferson St.
Ferrara, Joseph F.....1107 N. Main St.
Foster, Robert H. K.....301 E. Jefferson St.
Hibbs, William G.....Masonic Hospital
Jones, Charles A.....251 E. Jefferson St.
Mock, Harry E., Jr.....901 N. Main St.
Province, William D.....100 N. Main St.
Records, Arthur W.....198 E. Jefferson St.
Records, John M.....198½ E. Jefferson St.
Ritteman, George W..Johnson Co. Memorial Hosp.
Stogsdill, Willis W.....176 E. Jefferson St.
Walters, Jack L.....1551 N. Main St.
Waymire, William M.....1551 N. Main St.
Wesemann, Merrill M.....251 E. Jefferson St.

### Greenwood

Barnes, Helen Beall.....360 S. Madison Ave.
Brown, George E.....374 S. Madison Ave.
Link, Charles W., Jr.....365 E. Main St.
Ogle, Robert W.....365 E. Main St.
Sheek, Kenneth I.....188 S. Madison Ave.
Snodgrass, Robert E.....480 Beech Park Dr.
Tiley, George A.....41 N. Madison Ave.
Young, Joseph W.....365 E. Main St.

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Bullington, George E.....Whiteland
Machledt, John H.....Whiteland

## KNOX COUNTY

### Bicknell

Byrne, Robert J.....207 N. Main St.
Wilson, Guy H.....120 W. Third St.
Springstun, George H.....Oaktown

### Vincennes

Anderson, John B.....301 LaPlante Bldg.
Anderson, Richard M.....301 LaPlante Bldg.
Arbogast, Paul B.....915 Main St.
Barrett, Thomas L.....307 S. Fifth St.
Bartlett, Donald T.....307 S. Fifth St.
Beckes, Ellsworth W.....220 N. Fifth St.
Black, Boyd K.....Good Samaritan Hospital
Cantwell, Edgar R.....202 Broadway St.
Chattin, Herbert O.....729 Main St.
Coffel, Melvin H.....214 Buntin St.
Corsentino, Bart E.....Good Samaritan Hospital
Curtner, Myron L. (S).....222 N. Sixth St.
Edwards, Edward T.....34 S. Seventh St.
Ewing, Nathaniel D.....719 Nicholas
Hendrix, Charles E.....603 Busseron St.
Hoffman, Doris.....720 Perry St.
Humphreys, Joe E.....1516 N. Second St.
McCormick, Hubert D. (S)....325 LaPlante Bldg.
McDowell, Mordecai M.....611 Dubois St.
McMahan, Virgil C.....609 Dubois St.
Miller, Charles L.....301 American Bank Bldg.
Moore, Robert G.....21 N. Third St.
Nichols, Robert J.....605 Busseron St.
Parmenter, Harry B.....301 American Bank Bldg.
Reilly, James F.....401 Buntin St.
Shaffer, Kenneth L.....404 LaPlante Bldg.
Shanklin, Jack L.....607 Dubois St.
Smith, Ralph O.....603 Busseron St.
Smith, S. Joseph.....301 LaPlante Bldg.
Spencer, Frederic.....429 S. Sixth St.
Stein, Richard H.....301 American Bank Bldg.
Stewart, J. Frank W.....Hillcrest Hospital
Vaughn, Walter R.....615 Dubois St.
von der Lieth, William C.....719 Nicholas
Welch, Norbert M.....615 Dubois St.

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Tolbert, Robert D.....4310 Zelar St., Tampa, Fla.

## KOSCIUSKO COUNTY

Gill, Dee D.....Leesburg
Urschel, Dan L.....Mentone
Wilson, Wymond B.....Mentone
Pierson, Pearl H.....Silver Lake

### Warsaw

Arford, John E.....827 S. Union St.
Baum, John R.....212 S. Indiana
Brooks, Leonard C.....2022 E. Winona Ave.
Cron, William J.....215 S. High St.
Dormire, Robert D.....827 S. Union St.
DuBois, Charles C. (S).....800 E. Center St.
Hashemi, Hossein.....215 S. High St.
Haymond, George.....945 Country Club Lane
Hogle, Frank D.....R. F. D. 2
Keough, Thomas F.....600 E. Winona Ave.
Loudermilk, Richard G.....208 E. Center St.
Reed, Edgar A.....422 S. Buffalo St.
Shrader, Carl E.....600 E. Winona Ave.
Snider, Roland.....422 S. Buffalo St.
Thomas, Everett W.....212 S. Indiana

## LAGRANGE COUNTY

Taylor, M. Reed, Jr.....Howe
Yunker, Philip E.....Howe

### LaGrange

Benedict, Charles D.....203 W. Wayne St.
Flannigan, Harley F.....213 W. Lafayette
Studebaker, Lloyd R.....Medical Bldg.

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Williams, John H.....Shipshewana
Lehman, Kenneth M.....Topeka

Weir, Dale C.....3030 Beals Branch Rd., Louisville, Ky.

## LAKE COUNTY

### Cedar Lake

Babcoke, Gary A.....R. R. 2, Box 337
King, Robert W.....R. R. 1, Box 6
Miller, Donald C.....R. R. 2, Box 337
Misch, William.....R. R. 2, Box 337

### Crown Point

Becker, Philip H...Lake County Tuberculosis San.
Bernoske, Daniel G.
Lake County Health Dept., Courthouse
Birdzell, John P.....124 N. Main St.
Carroll, Mary E.....124 N. Main St.
Doherty, Raymond J.....47 W. 68th Place
DuSold, Donald D.....R. R. 1, Box 122
Fadul, Armand.....47 W. 68th Pl.
Gray, Daniel E.....182 W. North St.
Gutierrez, Peter E.....123 N. Court St.
Horst, William N.....123 N. Court St.
Majsterek, Stanley L.....R. R. 4, Box 31-B
Monroe, F. Bruce.....40 West 73rd St.
Russo, Andrew E.....123 N. Court St.
Steele, Everett B.....109 E. North St.
Troutwine, William R.....224 S. Court
Valenzuela, Roberto D.....Parramore Hospital

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Adler, Edmund R.....215 Joliet St., Dyer
Theobald, Sterling.....212 Joliet St., Dyer

### East Chicago

Barron, Elmer A.....3412 Michigan Ave.
Benchik, Frank A.....4712 Magoun Ave.
Boys, Fay F.....4712 Magoun Ave.
Braun, Benjamin D.....St. Catherine's Hospital
Broomes, Edward L. C.....2402 Broadway
Bryant, Edward G.....2220 Broadway
Campagna, Ettor A.....3406 Guthrie St.
Dainko, Alfred J.....915 W. Chicago Ave.
Fedor, Thomas A.....3406 Guthrie St.
Fleischer, Jacob C.....4035 Elm St.
Frahm, Charles.....4321 Fir St.
Given, Gilbert Z.....1802 E. Columbus Dr.
Govorchin, Alexander.....4614 Baring
Grosso, William G.....1919 E. Columbus Dr.
Harper, James W.....3847 Euclid
Hayes, Jesse D.....4804 Alexander
Hernandez, I. C.....1802 Columbus Dr.
Irish, Wilbur J.....806 W. Chicago Ave.
Jacobo, Miguel J.....3406 Guthrie
Johns, David R. (S).....1211 Beacon St.
Kmak, Chester J.....815 W. Chicago Ave.
Kopanko, Bernard F.....915 W. Chicago Ave.
Levin, Eli L. (S).....4105 Grand Blvd.
McGuire, Desmond F. (S)....3429 Michigan Ave.
Marks, Ora L.....815 W. Chicago Ave.
Marquinez, Adoracion A.....4124 Elm St.
Martirez, Napoleon A.....4710 Indianapolis Blvd.
Medina, Juan J.....1820 E. Columbus Dr.
Milan, Shijachki D. .....622 W. Chicago Ave.
Nicosia, John B.....1802 E. Columbus Dr.
Payne, Arthur C.....2020 Broadway
Ramos, John C.....3738 Main St.
Reitman, Paul H.....4321 Fir St.
Romero, Plinio.....3807 Main St.
Serna, Jesus A.....3619 Main St.
Shulruff, Harry I.....3701 Main St.
Strom, Jack.....1820 E. Columbus Dr.
Teegarden, Joseph A., Jr...1919 E. Columbus Dr.
Teplinsky, Louis L.....1802 E. Columbus Dr.
Trepagnier, Francis B.....2108 Broadway
Vergara, Abelardo.....4124 Elm St.
Walker, Adolph P.....1820 E. Columbus Dr.
Wang, Tieh C.....4321 Fir St.
Zallen, Stanley G.....720 W. Chicago Ave.

### Gary

Abramson, Allan L.....3290 Grant St.
Agana, Adriano A.....5000 W. Ridge Rd.
Alfano, Paul A.....2717 Wabash
Almquist, Carl O. (S).....504 Broadway
Alvarez, Paul.....4655 Broadway
Ambrozaitis, Kazys.....1600 W. Sixth Ave.
Amico, Pasquale J.....6111 Harrison St.
Angeles, Uldarico A.....1600 W. Sixth Ave.
Armalavage, Leon J.....6111 Harrison St.
Barton, Reginald R.....427 S. Lake
Behn, Walter M. (S).....1514 W. Fifth Ave.
Bendler, Carl H.....3290 Grant St.
Bergal, Milton B.....504 Broadway
Bernard, Marvin R.....4431 Broadway
Bills, R. James.....504 Broadway
Bills, Robert N.....504 Broadway
Boone, Clarence W.....1649 Broadway
Bornstein, Herschel.....504 Broadway
Brady, Samuel J.....504 Broadway
Brand, Anna.....4938 W. Fifth Ave.
Brandman, Harry.....504 Broadway
Brincko, John.....504 Broadway
Brink, Calvin C. (S).....411 W. Eighth Ave.
Brown, Leo R.....3290 Grant St.
Burcham, James B.....738 Broadway
Cahue, Antonio R.....6111 Harrison St.
Carberry, George A.....3656 Grant St.
Carbone, Joseph A.....6111 Harrison St.
Carey, J. Albert.....2964 W. 11th Ave.
Carmody, Raymond F.....6111 Harrison St.
Choslovsky, Sydney.....1600 W. Sixth Ave.
Chube, David D.....1606 Broadway
Cohen, Hyman.....1600 W. Sixth Ave.
Cooper, Leo K.....504 Broadway
Corrao, Gaetano.....2471 Colfax
Daniel, Robert A.....738 Broadway
Darling, Dorothy R.....807 Fayette
Dasaro, George E.....504 Broadway
Davis, Neal.....1600 W. Sixth Ave.
De Bois, Elon.....1080 Roosevelt
Dierolf, Edward J.....504 Broadway
Disney, Charles T.....504 Broadway
Donchess, Joseph C.....215 Broadway
Doneff, Ronald H.....5490 Broadway Plaza
Dosado, Elpidio B.....625 Washington St.
Duncan, John S.....2165 W. 11th Ave.
English, Hubert M.....673 Broadway
Espy, Theodore R.....1901 Broadway
Fadell, Matthew J.....6111 Harrison St.
Galante, Vincent J.....St. Mary Mercy Hospital
Gallinatti, John J.....554 S. Lake
Gilles, Pierre.....1649 Broadway
Glover, William J.....6111 Harrison St.
Goldberg, Harold B.....3656 Grant
Golding, Robert F.....P. O. Box 727
Goldstone, Adolph.....3229 Broadway
Goldstone, Arthur.....3233 Broadway
Goldstone, Joseph.....3229 Broadway
Goldstone, Robert J.....3229 Broadway
Goldstone, Sidney R.....3233 Broadway
Goodwin, Thomas.....3820 Central, East Gary
Grant, Benjamin F.....1706 Broadway
Gregoline, Amadeo F.....729 Broadway
Gregoline, Eugene.....847 W. 35th Ave.
Hadey, James H.....2620 W. Fifth Ave.
Haith, John W.....1960 W. 11th St.
Halley, Robert.....6111 Harrison St.
Han, Daniel.....1600 W. Sixth Ave.
Hedrick, James T.....1649 Broadway
Hewlett, George R.....6111 Harrison St.
Hodurski, Zigfield.....4319 Broadway
Hoit, Leonard.....504 Broadway
Holliday, Alfonso.....1649 Broadway
Jahns, Albin A.....2318 W. Fifth St.
Johnson, Arnold L.....1903 Broadway
Johnson, Lonnie B. (S).....123 W. 21st St.
Johnson, William H.....6111 Harrison St.
Jones, Harold N.....649 Taft St.

Kaltenthaler, Albert.....1600 W. Sixth Ave.
Kamen, Jack M.....1600 W. Sixth Ave.
Kendrick, Frank J.....504 Broadway
Khaton, Odessa M.....1649 Broadway
Klaus, Julius M.....4645 Broadway
Kobrin, Meyer W.....3229 Broadway
Kolettis, John G.....6111 Harrison St.
Kopcha, Joseph E.....504 Broadway
Korn, Jerome M.....3290 Grant St.
Lebioda, Henry S.....6111 Harrison St.
Lewis, George N.....504 Broadway
Lewis, Lucien A.....1649 Broadway
Lipschutz, Harold.....504 Broadway
Lipsey, Alfred J.....504 Broadway
Loh, Hwei-Ya (Chang).....212 Cleveland St.
Loh, Wei-Ping.....212 Cleveland St.
Lorenty, Thaddeus B.....504 Broadway
Lovell, Martin H. (S).....124 W. 25th Ave.
Lutz, Georgianna.....504 Broadway
Lytwakiwsky, Anatol.....552 S. Lake
McDonald, Walter E.....1721 Broadway
McMath, Samuel B.....1649 Broadway
Manalo, Francisco S.....538 Lincoln
Marcus, Morris C. (S).....3229 Broadway
Marshall, Millard R.....1215 Vermillion St.
Mather, J. Winford....2250 Ripley St., East Gary
Matsis, John P.....6111 Harrison St.
May, Richard M.....583 Broadway
Mayorga, Alfredo.....6111 Harrison St.
Milos, Robert J.....504 Broadway
Minczewski, Richard C.....5490 Broadway Plaza
Mirich, Ernest C.....6111 Harrison St.
Mitchell, Georgia B.....1706 Broadway
Molengraft, Cornelius J.....504 Broadway
Moore, Edwin G.....26 E. 15th Ave.
Morris, Hyman R.....3229 S. Broadway
Moswin, Jack A.....504 Broadway
Mott, William H.....2009 Broadway
Nelson, Walfred A.....559 S. Lake St.
Oberlander, Seymour.....3290 Grant St.
Olivo, Marciano T.....1600 W. Sixth Ave.
Olson, Leslie D.....2318 W. Fifth Ave.
Ornelas, Joseph P.....6111 Harrison St.
Pappas, Eddie T.....2717 Wabash Ave.
Parratt, Louis W.....708 Broadway
Penn, Robert A.....3820 Central Ave., East Gary
Pettis, Arthur G.....1600 W. Sixth Ave.
Pierson, Howard.....620 E. 10th Pl.
Platis, James M.....504 Broadway
Poracky, Bernard F.....504 Broadway
Pruitt, Jacob E.....6111 Harrison St.
Radigan, Leo R.....6111 Harrison St.
Reynolds, James S.....504 Broadway
Richter, Samuel.....504 Broadway
Riordan, John F.....1600 W. Sixth Ave.
Robinson, Walter K.....6111 Harrison St.
Rosenbloom, Philip J.....571 Lincoln St.
Ross, David E., Jr.....633 E. 21st Ave.
Roth, Leo.....3229 Broadway
Roth, Melvin I.....3229 Broadway
Rubin, Simon S.....504 Broadway
Ryan, Hubert J.....5490 Broadway Plaza
Sala, Joseph J.....2705 Wabash
Sala, Walter R.....2705 Wabash
Schulz, Kurt J.....4655 Broadway
Schwarz, Mandel.....540 Tyler
Scully, John T.....2318 W. Fifth Ave.
Senese, Thomas J.....504 Broadway
Shaw, Gordon.....540 Tyler
Shellhouse, Michael.....3811 Washington St.
Shevick, Alexander.....2620 W. Fifth Ave.
Slama, George F.....6111 Harrison St.
Slama, John T.....6111 Harrison St.
Speer, Thomas A.....Gary Sheet & Tin Mills
Spellman, Frank W.....401 S. Lake
Spivack, Mary.....504 Broadway
Stern, Mona K.....7535 E. Harold St.
Stoycoff, Christ M. (S).....860 Broadway
Thomas, Daniel D.....3290 Grant St.
Thomas, Gerald J.....3920 Grant St.
Turgi, Robert W.....6111 Harrison St.
Valencia, Monico....2606 Central Ave., East Gary
Volan, George J.....2620 W. Fifth Ave.
Voorhies, McKinley.....1606 Broadway
Weiskopf, Henry S.....504 Broadway
Wharton, Russell O. (S).....6559 Ash Place
Williams, Alexander S.....436 W. 25th Ave.
Williams, Edwin D.....436 W. 25th St.
Williams, Fred R.....2501 Polk St.
Wing, Herman.....1600 W. Sixth Ave.
Yast, Charles J.....6111 Harrison St.
Yocum, Paul S., Jr.....504 Broadway
Yocum, William S.....9 W. Sixth Ave.
Young, George M.....3656 Grant St.
Young, Robert L.....504 Broadway
Zucker, Edward.....504 Broadway

### Griffith

Carpenter, Bennie F.....1212 N. Broad
Lundeberg, Ralph A.....1212 N. Broad St.
Moleski, Walter L.....401 N. Broad St.
Purcell, Richard J.....433 N. Glenwood
Siekierski, Joseph M.....145 N. Griffith

### Hammond

Adler, Fred .....2450 169th St.
Alfano, Joseph E.....5252 Hohman Ave.
Bacevich, Andrew J.....2450 169th St.
Balaguer, Carmen V.....St. Margaret Hospital
Bethea, Dennis A. (S).....1021 Field St.
Brennan, Bess B.....2450 169th St.
Church, Robert A.....837 169th St.
Costello, Albert J.....30 Douglas St.
Cotter, Edward R.....2415 169th St.
Davis, Thomas N. III.....5246 Hohman Ave.
Eggers, Ernest L. (S).....635 165th St.
Eggers, Henry W.....30 Douglas St.
Egnatz, Nicholas.....820 Highland
Elledge, Ray (S) .....6415 Forest Ave.
Fischer, Burnell.....St. Margaret Hosp.
Fitzpatrick, William J.....30 Douglas St.
Friedman, Isadore E.....7217 Indianapolis Blvd.
Hopkins, Joseph R.....430 Conkey
Howard, William Harry.....5231 Hohman Ave.
Jones, Eli S.....30 Douglas St.
Kenney, Francis D.....30 Douglas St.
Kolanko, Leon A.....30 Douglas St.
Koransky, David S.....6860 Hohman Ave.
Kuhn, Arthur J.....112 Rimbach St.
Kuhn, Hedwig S.....112 Rimbach St.
LaFollette, Forrest R.....2450 169th St.
Lautz, Herbert A.....112 Rimbach St.
Long, Keith J.....30 Douglas St.
McVey, Clarence A. (S).....5231 Hohman Ave.
Marcus, Emanuel.....7127 Indianapolis Blvd.
Marks, Salvo P.....6860 Hohman Ave.
Maroc, James A.....837 169th St.
Marshall, Wilbur J., Jr.....30 Douglas St.
Mason, Richard L..... 132 Rimbach St.
Modjeski, Joseph R.....5451½ Hohman Ave.
Montes, Herminio Y.....5217 Hohman Ave.
Palmer, Barron M. F.....6134 Columbia
Panares, Solomon V.....5434 Hohman Ave.
Peck, Edward A.....430 Conkey St.
Peiffer, Geraldine M.....St. Margaret Hospital
Pilot, Jean.....5231 Hohman Ave.
Premuda, Franklin F.....6625 Kennedy Ave.
Ramker, Daniel T.....7040 Kennedy Ave.
Rawlins, Carolyn M.....6223 Hohman Ave.
Remich, Antone C.....30 Douglas St.
Rendel, Donald T.....5231 Hohman Ave.
Repay, Walter A.....429 Conkey St.
Rhind, Alexander W.....422 Conkey St.
Rosenthal, Carl.....St. Margaret Hospital
Rosevear, Henry J.....30 Douglas St.
Row, Perrie Q.....6712 Hohman Ave.
Rubright, Robert L.....7258 Forest Ave.

Schwartz, Mary M.....St. Margaret Hospital
Shapiro, Joseph.....2450 169th St.
Shapiro, Seymour W.....2450 169th St.
Smitley, Roger P.....30 Douglas St.
Solis, Roger V.....422 Conkey St.
Stasick, Murray.....7330 Indianapolis Blvd.
Stern, Samuel L.....5231 Hohman Ave.
Tilka, Edward C.....7134 Calumet Ave.
Weissman, Charles G.....5246 Hohman Ave.
White, Gilbert H., Jr.....2450 169th St.
Wong, Samuel N.....30 Douglas St.

**Highland**

Angel, Virgil E.....2933 Jewett
Bonaventura, Angelo P.....2914 Highway Ave.
Eugenides, Tatiana.....8136 Kennedy
Marquinez, Apolinario.....2914 Highway Ave.
Santiago, Iluminada.....8127 Kennedy
Sroka, Stanley J.....2942 Highway Ave.
Vore, Hugh A. (S).....8680 Prairie Ave.

**Hobart**

Carter, John O.....295 S. Wisconsin St.
Faulkner, Donald J.....295 S. Wisconsin St.
Kellar, Philip E.....701 N. Ridge Rd.
Krsek, Archie J.....10 N. Michigan Ave.
Markle, Joseph G.....201 Main St.
Parker, Harry C. (S).....831 Garfield St.
Pike, Warren H.....108 E. Third St.
Reed, John J.....10 N. Michigan Ave.
Stookey, Richard D.....295 S. Wisconsin
Thomas, Andrew C.....124 Main St.
Weiss, John T.....295 S. Wisconsin St.

**Lowell**

Mirro, John A.....317 W. Commercial Ave.
Smith, Robert D.....308 E. Commercial
Templin, David B.....308 E. Commercial

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Wimmer, Robert N. (S).....101 Superior St., Michigan City

**Munster**

Allegretti, Michael L.....7905 Calumet Ave.
Alt, Edward M., Jr.....7550 Hohman Ave.
Arbeiter, Herbert I.....7550 Hohman Ave.
Arrowsmith, James L.....7550 Hohman Ave.
Avegno, John H.....7905 Calumet Ave.
Beconovich, Robert.....7905 Calumet Ave.
Bombar, Leslie E.....8318 Oakwood
Branco, Arthur M.....7905 Calumet
Brenner, Howard B.....7905 Calumet Ave.
Chael, Thomas C.....7905 Calumet Ave.
Espino, Jose C.....8144 Calumet Ave.
Fetrow, Kenneth O.....7905 Calumet Ave.
Fox, Jack M.....7550 Hohman Ave.
Gardiner, H. Glenn.....7905 Calumet Ave.
Gevirtz, Milton B.....7905 Calumet Ave.
Griffith, Thomas E.....509 Ridge Rd.
Hammond, Stanley.....7905 Calumet Ave.
Harvey, David M.....7905 Calumet Ave.
Hehemann, William V.....7905 Calumet Ave.
Husted, Robert G.....7905 Calumet Ave.
Kott, Alexander.....7550 Hohman Ave.
Lanman, John U.....8146 Calumet Ave.
Larrabee, James F.....7905 Calumet Ave.
Luce, John W.....7905 Calumet Ave.
McLean, James S.....1836 Ridge Road
Madlang, Rodolfo M.....7550 Hohman Ave.
Mansueto, Mario D.....509 Ridge Rd.
Mason, John C.....7905 Calumet Ave.
Mintz, Alfred M.....7550 Hohman Ave.
Navarre, Vincent J.....509 Ridge Rd.
Neal, Leonard W.....7905 Calumet Ave.
Paul, Eudell G.....7550 Hohman Ave.
Portney, Fred R.....7905 Calumet Ave.
Rasch, George C., Jr.....509 Ridge Road
Rudolph, Franklin G.....7550 Hohman Ave.
Santare, Vincent J.....7550 Hohman Ave.
Schlesinger, Daniel J.....7905 Calumet Ave.
Schmitt, Robert J.....7905 Calumet Ave.
Schwartz, Jack.....7550 Hohman Ave.
Smith, Jerald E.....7905 Calumet Ave.
Snyder, Jerome A.....7905 Calumet Ave.
Stevens, Edwin W.....7905 Calumet Ave.
Sweany, Stanford K.....7550 Hohman Ave.
Trachtenberg, Lee.....8231 Calumet Ave.
Westhaysen, Peter V.....7550 Hohman Ave.
White, Jules C.....7905 Calumet Ave.
Wooden, Thomas F.....8351 Crestwood Ave.

**Portage**

Hoham, Frederick D.....14000 Central

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Egnatz, Charles D.....Rts. 41 and 30, Schererville
Skeen, Earl D. (S)..419 N. Sunnyside, South Bend

**Whiting**

Becker, Samuel W.....2075 Indianapolis Blvd.
Best, Robert C.....2075 Indianapolis Blvd.
Brennan, William C.....2075 Indianapolis Blvd.
Feinberg, Irwin I.....2075 Indianapoils Blvd.
Ferry, John L.....2075 Indianapolis Blvd.
Frankowski, Clementine E...1907 New York Ave.
Goldenberg, Mitchell E.....2075 Indianapolis Blvd.
Greisen, Jack G.....2075 Indianapolis Blvd.
Gustaitis, John W.....2075 Indianapolis Blvd.
Kelly, Francis J.....2815 Indianapolis Blvd.
Kudele, Louis T.....1321 119th St.
Polite, Nicholas L.....2075 Indianapolis Blvd.
Reed, Ronald R.....2075 Indianapolis Blvd.
Rudser, Donald H.....2075 Indianapolis Blvd.
Serna, Carlos A.....2075 Indianapolis Blvd.
Siler, George S.....2815 Indianapolis Blvd.
Silvian, Harry A.....1010 119th St.
Smith, Theodore J.....1542 Roberts
Sokol, Allen B.....2075 Indianapolis Blvd.
Stecy, Peter.....1902 Indianapolis Blvd.
Steen, Lowell H.....2075 Indianapolis Blvd.
Troy, Jack M.....2075 Indianapolis Blvd.
Vandertoll, Donald.....2075 Indianapolis Blvd.
Weinberg, Benjamin A.....1346 119th St.

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Angulo, Edilberto D...3232 Ridge Rd., Lansing, Ill.
Bakos, Edward R.....7203 Sarah, Apt. 4, Maplewood 17, Mo.
Dimitroff, Lambro.....211 Gold Coast Line Calumet City, Ill.
Dumanian, Ara V.....18668 Dixie Highway, Homewood, Ill.
Feldner, Ronald P...704 Wentworth, Calumet City, Ill.
Foster, Douglas L.
U. S. Naval Hospital, Philadelphia, Pa.
Hayes, Frank W.....Letterman Gen. Hosp., Presidio of San Francisco, Calif.
Hoskins, Phillip A.
824 Edgewood Pl., Ann Arbor, Mich.
McMichael, Frank J. (S)..Box 277, Hernando, Fla.
Murphy, Joseph F.....3508 Ridge Rd., Lansing, Ill.
Sargent, Wallace B.
P. O. Box 303, Russellville, Ala.
Seyler, Anna G.....2780 Hillcrest Dr., LaVerne, Calif.
Tsatsos, George C.
701 Gunderson Ave., Oak Park, Ill.
Tyrrell, Joseph J.....800 State Line, Calumet City, Ill.
Tyrrell, Thomas C.
800 State Line, Calumet City, Ill.
Yanson, Mannfredo R. S...P.O. Box 2024, Oxnard, Calif.

## LA PORTE COUNTY

Oak, David D., Jr.....Hanna
Oak, David D., Sr. (S).....LaCrosse

**La Porte**

Backer, George P.....806 Maple Ave.
Backer, Mary B.....903 Indiana Ave.
Carpentier, James R.....1200 Michigan Ave.
Carter, Fred S.....1200 Michigan Ave.
Datzman, Basil J.....216 E Street
Deren, Matthew J.....1012 Michigan Ave.
Durham, Lowell J.....316 Pine Lake Ave.
Erwin, W. Robert.....216 E St.
Farnsworth, Samuel A.....1012 Michigan Ave.
Feinn, Harry S.....1013 Indiana Ave.
Fischer, Carlton N.....1001 Maple Ave.
Kelsey, Robert M., Jr.....1200 Michigan Ave.
Kepler, Robert W.....708 Harrison St.
Kistler, James J.....911 Maple Ave.
Lansford, Kenneth G.....1200 Michigan Ave.
Larson, Goyt O.....1110 Indiana Ave.
Mead, Frank E.....901 Indiana Ave.
Moore, William G.....1200 Michigan Ave.
Mueller, Edwin C.....1200 Michigan Ave.
Philbrook, Seth S.....705 Harrison St.
Predd, Adolph C.....909 Madison St.
Richter, John C.....1200 Michigan Ave.
Sanchez, Jose D.....403 First Natl. Bank Bldg.
Scott, John S.....806 Maple Ave.
Sirugo, Aldo C.....1200 Michigan Ave.
Sprecher, James J. J.....102 Lincolnway
Tabaka, Francis B.....1201 Michigan Ave.
von Asch, George.....912 Monroe St.
Wolf, William E.....Lakewood Lair, The Island

**Michigan City**

Armstrong, Thomas D.....120 W. Ninth St.
Arney, Amos.....125 E. Fifth St.
Baker, Warren.....427 Warren Bldg.
Balingit, Benjamin L.....214 E. 10th St.
Bankoff, Milton L.....125 E. Fifth St.
Bergan, Joseph A.....217 W. Homer St.
Berkson, Myron E.....801 Washington St.
Carlson, Norman R.....913 Wabash St.
Fargher, Francis M.....907 Washington St.
Frost, Robert J.....817 Pine St.
Gardner, Melvin D.....801 Washington St.
Gardner, Russell A.....801 Washington St.
Gilmore, Robert W.....304 Warren Bldg.
Gilmore, Russell A. (S).....304 Warren Bldg.
Hay, Gene R.....515 Pine St.
Henderson, Norman C.....131 E. Eighth St.
Hillenbrand, Charles.....128 W. 10th St.
Jones, King S.....328½ Franklin St.
Kemp, John T.....122 E. Seventh St.
Kerr, Charlotte H.....723 Franklin St.
Kerr, John E.....723 Franklin St.
Kerrigan, John F.....916 Washington St.
Kerrigan, Robert L. (S).....916 Washington St.
Kubik, Francis J.....902 Pine St.
Lawrence, John O.....732 Pine St.
Liddell, Charles K.....508 Pine St.
Mannion, Rodney A.....723 Franklin St.
Marske, Robert L.....311-13 Warren Bldg.
McGue, Frank J.....801 Washington St.
Miller, Maurice.....125 E. Fifth St.
Milne, Walter S.....916 Washington St.
Mladick, Edward A.....1412 Franklin St.
O'Brien, Raymond J.....1412 Franklin St.
Paul, Leonard G.....515 Pine St.
Phillips, John H.....801 E. 11th St.
Pilecki, Peter J.....125 E. Fifth St.
Plank, Charles R.....732 E. Pine St.
Quitasol, Zoilo A., Jr.....125 E. Fifth St.
Reed, Nelle C. (S).....3210 Tilden Ave.
Stark, William A.....1412 Franklin St.
Taub, Robert G.....125 E. Fifth St.
Tunnell, Harry D.....219 E. Sixth St.
Walters, William H.....3714 Franklin St.
Warren, Lewis T.....2936 Belle Plaine
Weeks, Patrick H. (S).....305 N. Carroll Ave.
Weiss, Albert E.....125 E. Fifth St.
Zalac, Donald A.....732 Pine St.

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Weinstock, Adolph.....Rolling Prairie
Moosey, Louis.....Union Mills
Rohrer, Bryce B...506 Roosevelt Rd., Walkerton
Benz, Owen F.....Wanatah

**Westville**

Bosler, Howard A.....Beatty Circle
Brauer, Abraham A.....Beatty Memorial Hospital
Constan, Evan.....Beatty Memorial Hospital
Dian, August J.....Beatty Memorial Hospital
Dian, Julia K.....Beatty Memorial Hospital
Dieter, William J.....Box 667
Hetman, Mitchell J.....Westville
Matthew, John R.....Beatty Memorial Hospital
Meyer, Hans.....Beatty Memorial Hospital
Morton, David P.....Beatty Memorial Hospital
Oster, Jack H.....Beatty Memorial Hospital
Ritchie, Richard F.....Beatty Memorial Hospital
Salzburg, Herbert E....Beatty Memorial Hospital
Sennett, Cecil M. (S)..Beatty Memorial Hospital
Smith, William M.....Beatty Memorial Hospital

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Elshout, Clem H.....2001 Washtenaw Ave., Ann Arbor, Mich.
Johnston, Donald D. (S)
1010 Camino Flores, Thousand Oaks, Calif.
Kelsey, Robert M., Sr.....2501 Harbor Blvd., Costa Mesa, Calif.

## LAWRENCE COUNTY

**Bedford**

Allen, L. Howard.....1622 24th St.
Austin, Richard P...209 Citizens Nat'l Bank Bldg.
Benham, Lawrence E...310 Stone City Bank Bldg.
Bridwell, Edgar.....1626 24th St.
Duncan, Raymond.....2900 W. 16th St.
Dusard, Joseph C...304 Citizens Nat'l Bank Bldg.
Edmonds, Kendrick.....Dunn Memorial Hospital
Emery, Charles B.....1027 15th St.
Fountaine, Thomas J.....1618 24th St.
Hammel, Howard T.....Citizens Nat'l. Bank Bldg.
Hawkins, Richard D.....2900 W. 16th St.
Kasting, Gerald....206 Citizens Nat'l Bank Bldg.
Kerr, Donald M.....2900 W. 16th St.
McPike, Joseph D.....1103 Lincoln Ave.
Morrow, Robert J.....1317 L St.
Noe, William R.....2900 W. 16th St.
Reuter, John W.....1310 16th St.
Scherschel, John P.....1711 H St.
Waldo, Guy H.....2900 W. 16th St.
Wohlfeld, Julius B.....1222 15th St.
Woolery, Richard H.....1310 W. 16th St.

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Hamilton, James R...111 S. Seventh St., Mitchell
Oswalt, James T.....Mitchell

## MADISON COUNTY

**Alexandria**

Gaunt, Everett W.....214 E. John St.
Leroy, Alvin G.....1309 N. Harrison St.
Overpeck, George H.....313 N. Harrison St.
Owen, Thomas F.....313 N. Harrison St.
Shafer, Richard H.....111 S. Harrison St.

**Anderson**

Aagesen, Walter J.....702 Anderson Bank Bldg.
Armington, Charles L...655 Anderson Bank Bldg.
Austin, Charles E.....1612 Westwood Ave.
Baughn, William L.....Guide Lamp
Beeler, Franklin K.....1931 Brown St.
Bixler, Donald P.....1931 Brown St.
Blassaras, Crist A.....2005 Broadway
Bowers, Charles R.....2009 Brown St.

Brauchla, Carl H. (S).....117 W. 17th St.
Bridges, Alvin L.....1302 Madison Ave.
Brock, Earl E. (S)....412 Anderson Bank Bldg.
Buckles, David L.....St. John's Hospital
Bush, Edward R.....704 E. Eighth St.
Castetter, Gregory K.....126 W. 12th St.
Denny, Melvin H.....Community Hospital
Dixon, Rex W.....934 W. Eighth St.
Doenges, James L.....1931 Brown St.
Donaldson, Frank C.....1931 Brown St.
Drake, James R.....229 Citizens Bank Bldg.
Drake, John C.....604 Anderson Bank Bldg.
Drennen, Robert V.....1424 E. Eighth St.
Dulin, Basil B.....St. John's Hospital
Ellis, Seth W.....717 Anderson Bank Bldg.
Elsten, Aubrey W.....1931 Brown St.
Faust, Howard M., Jr.....1508 N. Madison Ave.
Ferguson, Donald H.....2009 Brown St.
Fischer, Warren E.....St. John's Hospital
Gahimer, Joe E.....521 Citizens Bank Bldg.
Gante, Henry W. (S).....2005 Nichol Ave.
Jarrett, Paul E.....315 Citizens Bank Bldg.
Jones, Albert T.....3316 Cherry Rd.
Jones, David G.....1504 N. Madison Ave.
Jones, Horace E.....926 W. Vineyard
Kelly, Wendell C.....704 E. Eighth St.
Kiely, John T.....1931 Brown St.
King, Joseph W.....1110 N. Meridian St.
Kopp, William R.....333 Jackson St.
Lamey, James L.....447 Citizens Bank Bldg.
Lamey, Paul T.....423 Citizens Bank Bldg.
Land, Richard N.....2009 Brown St.
Larmore, Joseph L.....612 Anderson Bank Bldg.
Litzenberger, Sam W...610 Citizens Bank Bldg.
Long, Paul L.....710 Anderson Bank Bldg.
McDonald, Virgil G. (S).....1019 Delaware St.
Meister, Doris (S).....315 W. Ninth St.
Miethke, Richard P.....Delco Remy Div.
Moneyhun, James E.....2009 Brown St.
Morris, Robert A.....1309 Park Road
Neale, Alfred E.....1931 Brown St.
Nesbit, Leonard L.....415 Citizens Bank Bldg.
Patterson, William K...713 Anderson Bank Bldg.
Polhemus, Warren C.....1803 Pearl St.
Price, Ambrose M.....621 Citizens Bank Bldg.
Quickel, Daniel S. (S).....608 Central Way
Reed, Roger R.....412 Anderson Bank Bldg.
Rosenbaum, Lloyd E.....647 Citizens Bank Bldg.
Ross, Guy E.....1931 Brown St.
Sharp, William L.....559 Citizens Bank Bldg.
Sheldon, Suel A.....508 Anderson Bank Bldg.
Stamper, Joseph H.....412 Anderson Bank Bldg.
Stamper, Robert J.....412 Anderson Bank Bldg.
Starks, William O.....1307 Park Rd.
Stinson, William M.....333 Jackson St.
Taylor, James A.....Delco Remy Div.
Wagoner, John R.....708 Anderson Bank Bldg.
Webb, Harry D.....515 Citizens Bank Bldg.
Weiss, Louis L.....1225 N. Madison
Whitaker, Jack D.....Community Hospital
Wilder, Gordon B.....338 W. Eighth St.
Williams, Francis M.....1132 Central Ave.
Williams, Robert H.....1132 Central Ave.
Woodbury, Clarence R.....1307 Park Rd.
Wright, Cecil S.....207 Beverly Terrace

**Elwood**

Buechler, William F.....1817 S. A St.
Drake, Marion C.....1201 Main St.
Fitzpatrick, Harry W. (S)..1309 S. Anderson St.
Hanson, Martin F.....1102 S. Anderson St.
Hoppenrath, William H. (S).....1300 Main St.
Laudeman, Walter A.....1515 N. A St.
Oldag, George E.....1301 Main St.
Ploughe, Ralph R.....517 S. Anderson St.
Scea, Wallace A.....1601 S. Anderson St.
Ulrey, Robert P.....1201 Main St.

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Kepner, Robert S.....Chesterfield
Austin, Maynard A. (S)
3900 Washington Ave., Evansville
Ferrell, Mars B.....Fortville
Bishop, Harry A.....Frankton
Hammer, Jay W.
3340 N. Rex Dr., Indianapolis (22)
Ridgway, Alton H.....Lapel
Rinne, John I. (S).....Lapel
Williams, Robert D.....Markleville
Reynolds, Ralph E.....Middletown
Begley, Robert W.....200 W. State St., Pendleton
Benedict, Harold G.....P. O. Box 28, Pendleton
Leahy, Howard J.....103 E. State St., Pendleton
Van Ness, William C.....Summitville

## MARION COUNTY

*(Zip Code 462 plus zone number.)*

**Beech Grove**

Berger, Morley.....902 Main St.
Christie, Marvin C.....3655 S. Sherman Dr.
Dill, Charles W.....3655 S. Sherman Dr.
Kim, Young D.....136 N. 17th St.
Ramage, Walter F.....244 S. First St.
Reilly, Eva F.....St. Francis Hospital
Zerfas, Charles P. A.....926 Main St.

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Kime, Edwin N. (S)
1007 Greenwood Ave., Bloomington
Hasewinkel, Carroll W...R. R. 2, Box 354, Carmel
Harris, Paul N.
Eli Lilly & Co., Toxicology Bldg. Greenfield
Pierce, Emmett C., Jr.
Eli Lilly & Co., Box 708, Greenfield
DeMotte, C. Bowen...540 N. Madison, Greenwood
Onyett, Harold R.....R. R. 3, Box 32, Greenwood

**Indianapolis**

A

Addleman, Robert H.....5540 Woodside Dr. (8)
Adkins, Harold C.....409 E. 30th St. (5)
Albertson, Frank P.....3544 W. 16th St. (22)
Albrecht, Willard H..7400 Hollingsworth Dr. (68)
Aldred, Allen W.....2221 W. 79th St. (60)
Aldrich, Harry D.....201 Hume Mansur Bldg. (4)
Aldrich, Howard....4316 E. Washington St. (1)
Alexander, Ezra D.....906 W. 27th St. (8)
Alig, Vincent B.....1815 N. Capitol Ave. (2)
All, Barbara B.....1815 N. Capitol Ave. (2)
Allen, Robert K.....3202 N. Meridian St. (8)
Alley, Thomas W.....607 N. Tibbs Ave. (22)
Alvis, Edmond O. (S)..320 Hume Mansur Bldg. (4)
Anderson, James W.....623 N. West St. (2)
Anderson, Wendell C.
Indiana State Board of Health,
1330 W. Michigan St. (7)
Anshutz, William M.....Methodist Hospital (7)
Antreasian, Berj.....4829 E. 38th St. (18)
Appel, Richard H....320 Hume Mansur Bldg. (4)
Arbogast, John L.....I. U. Medical Center (7)
Arbuckle, William E. (S)....1150 S. Sheffield (21)
Armer, Robert M.....4701 W. 30th St. (24)
Armstead, John W.....2140 N. Capitol Ave. (2)
Arnold, Aaron L.....607 E. 38th St. (5)
Arnold, Robert D.....5470 E. 16th St. (18)
Aronson, Sidney S...618 Hume Mansur Bldg. (4)
Assue, Clare M.....LaRue D. Carter Hospital (7)
Avery, George O.....17 S. Traub (22)

B

Bachmann, Arnold J.....3440 N. Meridian St. (8)
Baird, Melvin S.....17½ W. 22nd St. (2)
Bakemeier, Otto H...5503 E. Washington St. (19)
Bakemeier, Robert E. 5503 E. Washington St. (19)
Baker, John C.....American United Life Ins. Co.,
30 W. Fall Creek Parkway (6)
Ball, Joseph E.....4312 E. 10th St. (1)
Banks, Horace M. (S)
3631 Forest Manor Ave. (18)

Baptisti, Arthur, Jr.
Marion Co. General Hospital (7)
Barry, Maurice J. (S)....501 Doctors' Bldg. (4)
Bartle, James L.....6604 Hythe Rd. (20)
Bartley, Max D.....607 Hume Mansur Bldg. (4)
Bastnagel, William F...3602 N. Meridian St. (8)
Bates, Laurence H.....I. U. Medical Center (7)
Batman, Gordon W.....1815 N. Capitol Ave. (2)
Battersby, J. Stanley....I. U. Medical Center (7)
Batties, Paul A.....2142 N. Capitol Ave. (2)
Bauer, Thomas B....408 Hume Mansur Bldg. (4)
Baumeister, Herbert E...1815 N. Capitol Ave. (2)
Baxter, John P.....1633 N. Capitol Ave. (2)
Beach, Robert R.
5810 E. Pleasant Run Pkwy., N. Dr. (19)
Beaver, Howard W.....2930 Madison Ave. (25)
Beck, Evart M.....915 E. 38th St. (5)
Becker, Harry G.....6060 College Ave. (20)
Beeler, John W.....Methodist Hospital (7)
Beeler, Raymond C. (S)
3777 N. Meridian St. (8)
Belshaw, George.....1640 N. Ritter Ave. (18)
Belt, James H.....6225 Broadway (20)
Benedict, Paul F.....3949 Meadows Dr. (5)
Bennett, Ivan F.
Lilly Clinic, Marion Co. General Hospital (7)
Bennett, James E.....I. U. Medical Center (7)
Berman, Edward J. ..920 Hume Mansur Bldg. (4)
Berman, Jacob K.....920 Hume Mansur Bldg. (4)
Berner, Herbert W., Jr...I. U. Medical Center (7)
Berry, John M.....7841 White River Dr. (40)
Beverland, Malon E. (S)
3036 E. Washington St. (1)
Bibler, Lester D.....1815 N. Capitol Ave. (2)
Biegel, Angenieta A.....I. U. Medical Center (7)
Bill, Robert O.....2901 N. Meridian St. (8)
Black, Henry R..Marion Co. General Hospital (7)
Blackford, Florence.....5909 E. 10th St. (19)
Blackford, Ralph E. (S)....5909 E. 10th St. (19)
Blackwell, Donald S.....1815 N. Capitol Ave. (2)
Blake, Albert L.....1802 N. Illinois St. (2)
Blatt, A. Ebner.....3400 N. Meridian St. (8)
Bloemker, Edward F.....2729 Shelby St. (3)
Boggs, Eugene F.....8 E. Troy Ave. (25)
Boling, Frederick F.....3049 S. Holt Rd. (41)
Boling, Grover C.....1440 E. 46th St. (5)
Bomalaski, M. Donald..St. Vincent's Hospital (7)
Bond, George S. (S)....1221 N. Delaware St. (2)
Bond, Virginia.....R. R. 17, Box 364 (23)
Bond, William H.....I. U. Medical Center (7)
Bonsett, Charles A.....Community Hospital (19)
Booher, Norman R.....447 E. 38th St. (5)
Booher, Olga Bonke.....447 E. 38th St. (5)
Booth, Boynton H...707 Hume Mansur Bldg. (4)
Bowman, George W. (S)....1101 W. 10th St. (7)
Boyer, Floyd A.....442 N. Drexel Ave. (1)
Brady, Thomas A.....1815 N. Capitol Ave. (2)
Brayton, John R., Sr...704 Underwriters Bldg. (4)
Brayton, Lee.....3930 N. Illinois St. (8)
Brickley, Harry D...605 Hume Mansur Bldg. (4)
Brickley, Richard A..605 Hume Mansur Bldg. (4)
Briggs, Robert W.....2140 N. Capitol (2)
Brillhart, James R.....1640 N. Ritter Ave. (18)
Brodie, Donald W.....817 C. of C. Bldg. (4)
Brooks, Fred R., Jr.....3349 Georgetown Rd. (24)
Brown, Archie E.....1220 S. Belmont Ave. (21)
Brown, David E.....1944 N. Capitol Ave. (2)
Brown, DeWitt W.....1633 N. Capitol Ave. (2)
Brown, Earl R., Jr.....Community Hospital (19)
Brown, Frances T.....2126 N. Talbot Ave. (2)
Brown, Frank M.....2875 Clifton (23)
Brown, Gordon T.....3989 Meadows Drive (5)
Brown, Wendell E.....3426 N. Meridian St. (8)
Browning, James S.....3120 N. Meridian St. (8)
Browning, William M.....428 Golf Lane (60)
Brownley, E. Jane..2840 N. High School Rd. (24)
Bruce, Reginald A.....848 Indiana Ave. (2)
Brueckmann, F. Robert
1815 N. Capitol Ave. #401 (2)
Bruetsch, Walter L..3000 W. Washington St. (22)
Burdette, Harold F.....3202 N. Meridian St. (8)
Burghard, Rolla D.....4829 E. 38th St. (18)
Butler, John O.....234 E. Southern Ave. (25)
Butler, Robert M.....3426 N. Meridian St. (8)

C

Cahn, Hugo M.....5420 N. College Ave. (20)
Cahn, Peter H.....315 Hume Mansur Bldg. (4)
Caldwell, Marilyn R.....111 E. 53rd St. (20)
Call, Herbert F.....2901 N. Meridian St. (8)
Call, William H.....1815 N. Capitol Ave. (2)
Campbell, H. Edwin, Jr.,
418 Hume Mansur Bldg. (4)
Campbell, John A.....I. U. Medical Center (7)
Campbell, Richard W.....703 E. 60th St. (20)
Campbell, Robert L.....1100 W. Michigan St. (7)
Canaday, James W. (S)....5154 Central Ave. (5)
Caplin, Irvin.....1815 N. Capitol Ave. (2)
Caplin, Samuel S.....4525 Indianola, #3 (5)
Carson, Wayne.....1802 N. Illinois St. (2)
Carter, James E.....I. U. Medical Center (7)
Cast, William R.....Methodist Hospital (7)
Chattin, William R.....4829 E. 38th St. (18)
Chavez, Mauro E.....5324 W. 16th St. (24)
Chen, Ko Kuei.....I. U. Medical Center (7)
Chernish, Stanley M.
Marion Co. General Hospital (7)
Chevalier, Robert B.
Marion County General Hospital (7)
Chivington, Paul V...407 Hume Mansur Bldg. (4)
Chroniak, Walter.....41 N. Shortridge Rd. (19)
Clark, Charles M., Jr....St. Vincent's Hospital (7)
Clark, George A.....922 Hume Mansur Bldg. (4)
Clark, Lawson J.....3736 N. Delaware St. (5)
Clevinger, William G.....1601 N. Whitcomb (24)
Close, W. Donald.....I. U. Medical Center (7)
Coates, Jacqueline.....305 W. 42nd St. (8)
Coggeshall, Warren E...3524 N. Meridian St. (8)
Cohn, Alvin F.....1120 Southview Dr. (27)
Collins, Hubert L.....985 N. Arlington Ave. (19)
Collins, Robert C.....1356 W. 21st St. (2)
Conley, Joseph L. (S).....405 E. 52nd St. (5)
Conway, Chester C.....4402 E. New York St. (1)
Conway, Glenn.....1620 S. East St. (25)
Cooke, J. Kenneth.....1315 W. 10th St. (7)
Cookson, Lawrence U... I.U. Medical Center (7)
Cornacchione, Matthew.....814 S. East St. (25)
Cortese, James V.....435 S. East St. (25)
Cortese, Thomas A., Jr.
2929 S. Pennsylvania St. (25)
Cortese, Thomas A.....435 S. East St. (25)
Costin, Robert L.....301 E. 38th St. (5)
Coughenour, J. Robert....2809 S. Holt Road (41)
Countryman, Frank W...1815 N. Capitol Ave. (2)
Craft, Kenneth L. (S)
1002 Hume Mansur Bldg. (4)
Craig, Alexander F.....5470 E. 16th St. (18)
Crawford, John A...321 Hume Mansur Bldg. (4)
Cronin, H. Joseph.....3400 N. Meridian St. (5)
Crosby, Reid C.....Methodist Hospital (7)
Cross, David G.....1002 Troy Ave. (3)
Culbertson, Clyde G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cullen, P. Kent, Jr.....310-11 Hume Mansur Bldg. (4)
Cullen, Paul K., Sr.....310-11 Hume Mansur Bldg. (4)
Culloden, William G. (S).....710 E. 46th St. (5)
Cunningham, Gene C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Cure, Charles W.....1815 N. Capitol Ave. (2)
Currie, Robert W.....512 E. 57th St. (20)
Curry, R. Louis .....3375 Forest Manor (18)
Cuthbert, Marvin P.....3400 N. Meridian St. (8)
Czenkusch, Helen G.....2840 High School Rd. (24)

D

Daley, Edward H.....5470 E. 16th St. (18)
Dallas, Fred R.....1640 N. Ritter Ave. (18)
Dallas, Mary E.
V. A. Hospital, 1481 W. 10th St. (7)

Dalton, William W....311 Hume Mansur Bldg. (4)
Daly, Joseph M.....234 E. Southern Ave. (25)
Daniel, John C. (S)....1008 Hume Mansur Bldg. (4)
Davidson, Dale A.....1815 N. Capitol Ave. (2)
Davidson, N. Cort.....3233 N. Meridian St. (8)
Davis, Bennie L.....2426 Northwestern Ave. (23)
Davis, Margaret M.....2603 W. 42nd St. (8)
Davis, Sam J.....908 Hume Mansur Bldg. (4)
Deal, Eleanor H..4909 W. 15th St., Speedway (24)
Dearmin, Robert M.....3233 N. Meridian St. (8)
DeArmond, Murray.....1815 N. Capitol Ave. (2)
Deever, John W.....4131 Shelby St. (27)
Deitch, Robert D.....234 E. Southern Ave. (25)
Dennison, Alfred D., Jr...1815 N. Capitol Ave. (2)
Denny, Forrest L.....3351 W. 10th St. (22)
Denny, James W.....25 N. Ritter Ave. (19)
DeWees, Dwight L.....302 N. Bradley Ave. (1)
DeWester, Gerald M.....3037 S. Meridian St. (27)
Dickson, Carolyn L.....501 N. West St. (2)
Dill, Myron K.....3120 N. Meridian St. (8)
Dillard, Andrew G.....I. U. Medical Center (7)
Dillon, John F.....Methodist Hospital (7)
Dilts, Robert L.....2521 E. 38th St. (18)
Dintaman, Paul G...703 Hume Mansur Bldg. (4)
Dolan, Patrick A.....Methodist Hospital (7)
Donahue, James M.....1815 N. Capital Ave. (2)
Donato, Albert M.....1429 Shelby St. (3)
Doran, J. Hal.....620 Hume Mansur Bldg. (4)
Doughty, Samuel R., Jr.....5470 E. 16th St. (18)
Douglas, William T.....I. U. Medical Center (7)
Dowd, Joseph A. .....6177 College Ave. (20)
Drew, Arthur L., Jr.....I. U. Medical Center (7)
Dryden, Gale E.....5835 N. Tacoma (20)
Dugan, William M., Jr...7521 Mohawk Lane (60)
Duncan, Stuart J.....3037 S. Meridian St. (27)
Duncan, William A.....1221 E. 86th St. (40)
Dunkin, Ramon S.....3202 N. Meridian St. (8)
Dyar, Edwin W.....1010 E. 86th St. (40)
Dyar, Robert W.....1010 E. 86th St. (40)
Dyke, Richard W. Marion Co. General Hospital (7)
Dyken, Mark L.....I. U. Medical Center (7)
Dzenitis, Andrievs J.....I. U. Medical Center (7)
Dziabis, Marvin D.....Methodist Hospital (7)

E

Earp, Evanson B.....717 Hume Mansur Bldg. (4)
Eastman, Joseph R., Jr.....220 W. 64th St. (60)
Eaton, Edwin R.....5505 N. Keystone Ave. (20)
Eaton, Lyman D.....5505 N. Keystone Ave. (20)
Ebert, J. Wayne.....1125 Southview Dr. (27)
Eberwein, John H. (S)....2322 Wheeler Ave. (18)
Echt, Charles R.....I.U. Medical Center (7)
Edwards, Wendell L.....3470 N. Meridian St. (8)
Egan, William P.....2811 Delores Dr. (22)
Egbert, Herbert L.....5317 E. 16th St. (18)
Eicher, Palmer O.....3400 N. Meridian St. (8)
Eldridge, Gail E.....1440 E. 46th St. (5)
Elkins, James P.....234 E. Southern Ave. (25)
Ellis, Charles R.....Methodist Hospital (7)
Ellis, William N.....1640 N. Ritter Ave. (18)
Emhardt, John T.....1628 S. East St. (25)
Emhardt, John W. A. (S)
5424 Washington Blvd. (20)
Evans, Daniel R.....I.U. Medical Center (7)
Evans, Frederick H.....2140 N. Capitol (2)
Evans, Paul V.....Methodist Hospital (7)
Everly, Ralph V.....668 E. 38th St. (5)

F

Failey, Robert B., Jr.....I. U. Medical Center (7)
Farrell, Joseph T.....2807 E. Michigan St. (1)
Fausset, C. Basil.....2901 N. Meridian St. (8)
Fechtman, William F.....I. U. Medical Center (7)
Feeney, Martin T.....St. Vincent's Hospital (7)
Ferry, Francis A.....1638 E. Raymond St. (3)
Finneran, Joseph C.....1802 N. Illinois St. (2)
Fisch, Charles.....I. U. Medical Center (7)
Fischer, A. Alan.....1745 Howard St. (21)
Fitzgerald, William J.
303 Fountain Square Theatre Bldg. (3)
Flanagan, Paul M.....3311 N. Meridian St. (8)
Flanders, Robert, Jr.....3202 N. Meridian St. (8)
Flanigan, Meredith B.....3305 Rutledge (8)
Fleischl, Herbert....Central State Hospital (22)
Flick, John J.....668 E. 38th St. (5)
Flora, Joseph O.....4317 W. Washington St. (41)
Folkening, Norval C...234 E. Southern Ave. (25)
Forbes, Robert S..4110 Crooked Creek Overlook (8)
Fortuna, Frank W.....5602 S. Madison Ave. (27)
Fosgate, Harold L.....4301 E. 38th St. (18)
Foster, John A.....Methodist Hospital (7)
Foster, Lee N.....St. Vincent's Hospital (7)
Foster, Ray D.....1944 N. Capitol Ave. (2)
Fouts, Paul J.....623 Hume Mansur Bldg. (4)
Franklin, William L..508 Hume Mansur Bldg. (4)
Franz, Sherman G...LaRue D. Carter Hospital (7)
Freed, Carl A.....2948 Kessler Blvd., N. Dr. (22)
Freeman, Leslie W.....I. U. Medical Center (7)
Freeman, Max E.....1745 Howard St. (21)
French, Richard N..LaRue D. Carter Hospital (7)
Fromhold, Willis A...611 Bankers Trust Bldg. (4)
Fry, Robert D.....517 Hume Mansur Bldg. (4)
Fugelso, Erling S...Marion County Gen'l Hosp. (7)
Fulper, James C.....3675 N. Post Road (26)
Fulton, William H.....1633 N. Capitol Ave. (2)
Fundenberger, Martin.....2815 E. 38th St. (18)

G

Gabovitch, Edward R.....1815 N. Capitol Ave. (2)
Gaddy, Euclid T....2602 W. Washington St. (22)
Gaddy, Nelson D..2602 W. Washington St. (22)
Galloway, John A.....Eli Lilly & Co., 740 S. Alabama St. (6)
Gambill, J. Randolph
LaRue D. Carter Hospital (7)
Gambill, William D.....1633 N. Capitol Ave. (2)
Gammieri, Robert L.....661 E. 49th St. (5)
Garceau, George J....508 Hume Mansur Bldg. (4)
Gard, Daniel A..Ford Motor Co., Box 19106 (19)
Gardiner, Sprague H.....I. U. Medical Center (7)
Gardner, Austin L.....3400 N. Meridian St. (8)
Gardner, Buckman....St. Vincent's Hospital (7)
Garfield, Martin D.....3705 College Ave. (5)
Garner, W. Stanley.....2704 E. 62nd St. (20)
Garrett, John D. (S)....402 N. Meridian St. (4)
Garrett, Robert A.....I. U. Medical Center (7)
Geider, Roy A.....1525 Prospect St. (3)
George, Charles L.....1121 E. 80th St. (40)
Gibson, Greta Maxine
5744 Broadway Terrace (20)
Gick, Herman H. (S)..2705 E. Michigan St. (1)
Gifford, Fred E.....710 Hume Mansur Bldg. (4)
Gillespie, Charles F.....3400 N. Meridian St. (8)
Gillespie, Jacob E...523 Hume Mansur Bldg. (4)
Gillim, Parvin D.....I. U. Medical Center (7)
Ginsberg, Stewart T.
LaRue D. Carter Hospital (7)
Glendening, John L. (S)
7202 N. Meridian St. (60)
Glover, John L.....3031 N. Centennial (22)
Goldman, Samuel...2117 W. Washington St. (22)
Gormley, Joseph J.....2327 Lafayette Rd. (22)
Gosman, James H.....2901 N. Meridian St. (8)
Graham, Edward W.
V. A. Hospital, 1481 W. 10th St. (7)
Graham, John D.....1802 N. Illinois St. (2)
Graham, William E.....3311 N. Meridian St. (8)
Gray, Kenneth L...2727 N. High School Rd. (24)
Grayson, Merrill.....I. U. Medical Center (7)
Grayson, Ted L.....1815 N. Capitol Ave. (2)
Green, Joseph B.....6816 W. 71st St. (78)
Green, Morris.....Riley Hospital (7)
Greene, Morgan E.....1621 S. East St. (25)
Gregory, Robert L.....1743 Shelby St. (3)
Greist, John H.....2901 N. Meridian St. (8)
Griffin, Leslie W...Allison Div., General Motors (6)
Griffith, Richard S.
Lilly Clinic, Marion Co. General Hospital (7)
Griffith, Ross E.....401 E. 34th St. (5)
Grimes, Hubert N.....Methodist Hospital (7)

Grisell, Ted L.....5317 East 16th St. (18)
Grosz, Hanus J.....I. U. Medical Center (7)
Gruber, Charles M.
Lilly Clinic, Marion Co. General Hospital (7)
Gumbert, Jack L.
Marion Co. General Hospital (7)

H

Habegger, Elmer D.....1815 N. Capitol Ave. (2)
Hackney, Victor C.....I. U. Medical Center (7)
Hadley, David .....702 Hume Mansur Bldg. (4)
Haggard, Edmund B.....932 Illinois Bldg. (4)
Hall, Frank M.....100 N. Senate Ave. (4)
Hall, Jack H.....Methodist Hospital (7)
Hamer, Homer G. (S)..1711 N. Capitol Ave. (7)
Hamilton, Howard B....764 S. Emerson Ave. (3)
Hampshire, Donald R.
1443 N. Pennsylvania St. (2)
Hancock, John G.....2226 W. Michigan St. (22)
Hann, Eldon C.....1633 N. Capitol Ave. (2)
Hanna, Thomas A.....1608 N. Lynhurst Dr. (24)
Hansell, Robert M....6049 E. Washington St. (19)
Harcourt, Allan K.....812 C. of C. Bldg. (4)
Harcourt, Robert S.....812 C. of C. Bldg. (4)
Harding, M. Richard.....3949 Meadows Dr. (5)
Harding, Myron S.....3949 Meadows Dr. (5)
Hare, Earl H. (S)
Indiana State Board of Health,
1330 W. Michigan St. (7)
Hare, Laura.....404 Hume Mansur Bldg. (4)
Harger, Robert W... 804 Hume Mansur Bldg. (4)
Harris, Carl B. ....319 Hume Mansur Bldg. (4)
Harris, James C.....1010 E. 86th St. (40)
Harvey, Verne K., Jr.
Indiana State Board of Health,
1330 W. Michigan St. (7)
Hatfield, Jack J.....5538 N. Keystone Ave. (20)
Hatfield, Nicholas W.....5851 E. 54th Pl. (26)
Hawk, James H.....3736 N. Delaware St. (5)
Haymond, Joseph L.....301 E. 38th St. (5)
Haynes, John T.....1815 N. Capitol Ave. (2)
Hays, Everett L. (S).....2607 Manker Ave. (3)
Healey, Robert J.....3602 N. Meridian St. (8)
Hedrick, Philip W.....1221 E. 86th St. (40)
Heimburger, Robert F...I. U. Medical Center (7)
Helmen, Charles H.....I. U. Medical Center (7)
Henderson, Francis G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Henderson, Roscoe C.
3131 Northwestern Ave. (23)
Henderson, William P.
520 Hume Mansur Bldg. (4)
Hendricks, Fred A...6921 N. Keystone Ave. (20)
Hendricks, John W...911 Hume Mansur Bldg. (4)
Henry, Russell S.....725 Hume Mansur Bldg. (4)
Hepburn, C. K.....1633 N. Capitol Ave. (2)
Hetherington, John A...1633 N. Capitol Ave. (2)
Heubi, John E.....668 E. 38th St. (5)
Hibner, Dan W.....215 E. New York St. (4)
Hickam, John B.....I. U. Medical Center (7)
Hickman, Jack W.
Marion Co. General Hospital (7)
Hickman, Walter F. (S)..1210 Oliver Ave. (21)
Hicks, Murwyn L.....5470 E. 16th (18)
Hicks, Wilbur P.....310 W. 40th St. (8)
Hildebrand, William L..2963 N. Sherman Dr. (18)
Hill, Herbert N.....3349 Georgetown Rd. (24)
Hill, James K.....4701 W. 30th St. (24)
Hilz, James M.....435 S. East St. (25)
Himler, James M.....809 Underwriters Bldg. (4)
Hines, Don C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Hoffman, Herman.....650 E. 38th St. (5)
Hofmann, J. William (S)
8360 Washington Blvd. (40)
Hogan, Michael A.....6214 Broadway (20)
Holland, William M.....I. U. Medical Center (7)
Holm, Leo H....Marion County General Hosp. (7)
Holman, Jerome E., Jr.....3315 E. 10th St. (1)
Holman, Jerome E., Sr. (S)..3315 E. 10th St. (1)
Holmes, George H., Jr.
313 Hume Mansur Bldg. (4)
Hood, Ainslee A.....3205 Shelby St. (27)
Hopkins, Bruce J.....St. Vincent's Hospital (7)
Horwitz, Thomas....421 Hume Mansur Bldg. (4)
Howell, Arthur.....305 W. 42nd St. (8)
Howell, Joseph D...760 Bankers Trust Bldg. (4)
Hoyt, Lester H.....Methodist Hospital (7)
Hoyt, Millard L.....612 Hume Mansur Bldg. (4)
Hubbard, Jesse D.....I. U. Medical Center (7)
Huber, Carl P.....I. U. Medical Center (7)
Hudson, Foster J. (S)...3440 N. Meridian St. (8)
Hull, Ronald H.....1815 N. Capitol Ave. (2)
Hummons, Francis D.
2229 Northwestern Ave. (23)
Hunt, H. Richard.....I. U. Medical Center (7)
Hurteau, William W.....Methodist Hospital (7)
Huse, William M.....1815 N. Capitol Ave. (2)

I

Irvine, William O.
V. A. Hospital, 1481 W. 10th St. (7)
Irwin, Glenn W., Jr.....I. U. Medical Center (7)
Iske, Paul G.....420 Hume Mansur Bldg. (4)

J

Jackson, James W. (S).....463 W. 32nd St. (8)
Jaeger, Alfred S. (S).3057 Washington Blvd. (5)
James, Charles E.....6939 N. Michigan Rd. (68)
Jaquith, Orville S. (S) ..261 Blue Ridge Rd. (8)
Jay, Arthur N.....3400 N. Meridian St. (8)
Jay, James M.....1633 N. Capitol Ave. (2)
Jenkins, Robert E.....3440 N. Meridian St. (8)
Jennings, Frank L. (S)
V. A. Hospital, 1481 W. 10th St. (7)
Jewett, Joe H.....3120 N. Meridian St. (8)
Jobes, James E.....110 N. Illinois St.,#413 (4)
Johnson, Earl H.....1802 N. Illinois St. (2)
Johnson, Thomas W.....1802 N. Illinois St. (2)
Jones, Allen W.....6060 College Ave. (20)
Jones, David E.....828 C. of C. Bldg. (4)
Jones, Francis P.....4212 E. Michigan St. (1)
Jones, George L.....8933 Southeastern Ave. (19)
Jones, Gordon C.....1517 N. Emerson (19)
Jontz, Jon P.....5470 E. 16th St. (18)
Joseph, Rex M.....59 E. Troy Ave. (25)
Jowitt, Richard H.....1502 N. Emerson (19)
Judd, Russell L.....5470 E. 16th St. (18)
Judson, Walter E.....I. U. Medical Center (7)

K

Kahler, Maurice V. (S)...2638 Kessler Blvd. (22)
Kahn, Alexander J.....3120 N. Meridian St. (8)
Kahn, Howard L.....3120 N. Meridian St. (8)
Kaiser, James L.....1815 N. Capitol Ave. (2)
Kalsbeck, John E.....I. U. Medical Center (7)
Kammen, Leo.....3202 W. 16th St. (22)
Karsell, William A.....3989 Meadows Dr. (5)
Katterjohn, James C..313 Hume Mansur Bldg. (4)
Kauffman, Nelson N....2901 N. Meridian St. (8)
Kebel, Arthur P.....4456 N. Keystone Ave. (5)
Keenan, George B.....3225 Shelby St. (27)
Keever, Charles H.....5214 College Ave. (20)
Keiser, Venice D. (S).....5709 Broadway (20)
Kelly, Don E.....702 Underwriters Bldg. (4)
Kennedy, Hunter F.....1229 Prospect St. (3)
Kennedy, Joseph T.....5470 E. 16th St. (18)
Kenney, David B.....I. U. Medical Center (7)
Kenzler, Jack I.....205 Hume Mansur Bldg. (4)
Kerr, Harry R.....2817 E. Washington St. (1)
Ketcham, Jane M. (S).....3906 Ruckle St. (5)
King, Harold.....I. U. Medical Center (7)
Kingsbury, John K. (S)
5462 E. Washington St. (19)
Kirkhoff, Paul J.....5317 E. 16th St. (18)
Kirklin, Oren L.....3222 E. 38th St. (5)
Kirtley, William R.
Eli Lilly & Co., 740 S. Alabama St. (6)

Kissel, Wesley A.....1815 N. Capitol Ave. (2)
Kitterman, Harry E.....5317 E. 16th St. (18)
Klain, Benjamin V.....4157 College Ave. (5)
Klingerman, John J.....6130 E. 43rd St. (26)
Klutinoty, George II.....3002 N. Tibbs Ave. (22)
Kneidel, John H.....3314 W. 16th St. (22)
Knowles, Charles Y.....5317 E. 16th St. (18)
Knowles, Robert P.
2948 Kessler Blvd., N. Dr. (22)
Kochell, Richard L.....St. Vincent's Hospital (7)
Kohlstaedt, Karl C.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kohlstaedt, Kenneth G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kooiker, John E.....1815 N. Capitol Ave. (2)
Koons, Karl M. (S)..923 Hume Mansur Bldg. (4)
Kopecky, Robert R.....4131 Shelby St. (27)
Kornafel, L. H.....905 Hume Mansur Bldg. (4)
Kraft, Bennett.....760 Bankers Trust Bldg. (4)
Kremp, Richard E.....6939 N. Michigan Rd. (68)
Kriel, William B.....5630 W. Washington St. (41)
Kuntz, Herman W..611 Hume Mansur Bldg. (4)
Kurlander, Gerald J.....I. U. Medical Center (7)
Kurtz, Fred B. (S).....5520 N. Illinois St. (8)
Kurtz, Philip L.
Eli Lilly & Co., 740 S. Alabama St. (6)
Kwitny, Isadore J.....3400 N. Meridian St. (8)

L

Lackey, John T..Marion County General Hosp. (7)
LaDine, Clarence B.....2508 Station St. (18)
Lamb, Emmett B.....205 Hume Mansur Bldg. (4)
Lamb, Russell W.....205 Hume Mansur Bldg. (4)
Lamber, Chet K.....914 Hume Mansur Bldg. (4)
Lamkin, E. Henry, Jr.....I. U. Medical Center (7)
Landwehr, Alfons.....Sunnyside Sanitorium (26)
Lane, C. Elaine.....2840 N. High School (24)
Lang, Erich K.....Methodist Hospital (7)
Lang, Jay W.....Marion Co. General Hospital (7)
Largaespada, Manuel.....549 S. Fleming (41)
Lashmet, Michael H..419 Hume Mansur Bldg. (4)
Lasich, Anthony R.....1815 N. Capitol Ave. (2)
Lawrance, Kingsley
Marion Co. General Hospital (7)
Lawson, Allan J.....1010 E. 86th St. (40)
Leasure, J. Kent (S)...3060 N. Meridian St. (8)
Leatherman, Harter L.....1502 E. 46th St. (5)
Leffel, James M.....1633 N. Capitol Ave. (2)
Leffler, William T.....2141 E. 52nd St. (5)
LeMaster, Theodore R.
305 Hume Mansur Bldg. (4)
Leser, Ralph U.....3233 N. Meridian St. (8)
Levi, Leon.....40 W. 38th St. (8)
Lewis, Paul S.....6357 Rockville Rd. (24)
Lewis, R. Earl.....2307 E. Raymond St. (3)
Lichtenberg, Melvin.....535 E. 38th St. (5)
Lidikay, Edward C.....3989 Meadows Dr. (5)
Lindenborg, Paul G..3016 N. Arlington Ave. (18)
Lingeman, Raleigh E...1944 N. Capitol Ave. (2)
Lingeman, Ralph B., Jr....I. U. Medical Center (7)
Link, Goethe (S).....401 N. Illinois St. (4)
Littlefield, Paul A.
4040 Crooked Creek Overlook (8)
Littlefield, Shirley D.....1815 N. Capitol Ave. (2)
Lloyd, Frank P.....Methodist Hospital (7)
Loehr, William M.....I. U. Medical Center (7)
Long, Malcolm D.....7605 Westfield Blvd. (40)
Loomis, Norman S.....5230 N. Kenwood Ave. (8)
Lord, Glenn C.....104 E. 38th St. (5)
Louden, Robert W.....1221 E. 86th St. (40)
Loughlin, L. Leo.....1815 N. Capitol Ave. (2)
Love, George N.....5331 Washington Blvd. (20)
Lozow, David.....4829 E. 38th St. (18)
Lucas, Clarence A., Jr....2012 Boulevard Pl. (2)
Lukemeyer, George T....I. U. Medical Center (7)
Lunsford, Thomas E....1815 N. Capitol Ave. (2)
Lurie, Paul R.....I. U. Medical Center (7)
Luros, J. Theodore.....1633 N. Capitol Ave. (2)
Lybrook, William B....3731 N. Keystone Ave. (18)
Lynn, Gene E.....1815 N. Capitol Ave. (2)

M

MacDougall, John D.....3949 Meadows Dr. (5)
McAlpine, Richard J..5704 N. Keystone Ave. (20)
McAree, Francis E., Jr.....5470 E. 16th St. (18)
McBride, James S. (S).....720 E. 80th St. (40)
McCallum, Donald C.....1815 N. Capitol Ave. (2)
McCallum, Joseph T. C. (S)..237 W. 46th St. (8)
McCallum, Robert N.....1815 N. Capitol Ave. (2)
McCartney, Donald H.
1021 Hume Mansur Bldg. (4)
McClain, Edwin S...414 Hume Mansur Bldg. (4)
McCormick, Charles O., Jr..3989 Meadows Dr. (5)
McGrath, Michael F.....1929 E. 38th St. (18)
McIntyre, Charles J. (S).3930 Carrollton Ave. (5)
McIntyre, James M.....2901 N. Meridian St. (8)
McKinley, A. David.....I. U. Medical Center (7)
McLaren, Daniel E.....6000 E. 46th St. (26)
McNutt, Cyrus C.....Methodist Hospital (7)
McQuiston, Ralph J.....608 Guaranty Bldg. (4)
McTurnan, Robert W.....5646 N. Illinois St. (8)
Mackey, John E.....3400 N. Meridian St. (8)
Madden, Robert J.....4612 E. 10th St. (1)
Madtson, A. Ricks.1815 N. Capitol Ave. #307 (2)
Magennis, Herbert L. (S)..8417 Compton Dr. (40)
Manalan, Maurice M.
5831 E. Washington St. (19)
Manders, Karl L.....3400 N. Meridian St. (8)
Manion, Marlow W...601 Hume Mansur Bldg. (4)
Mann, Mortimer.....3426 N. Meridian St. (8)
Manning, K. Randolph..1815 N. Capitol Ave. (2)
Manzie, Michael W.....2372 Lafayette Rd. (22)
Marks, Maurice I.....2901 N. Meridian St. (8)
Markstone, David H.....I. U. Medical Center (7)
Marsh, Carl M.....101 N. Shortridge Rd. (19)
Marshall, Albert L., Jr.
Indiana State Board of Health,
1330 W. Michigan St. (7)
Marshall, Cavins R. (S) .....43 W. 30th St. (8)
Martin, Hugh E.
Pitman-Moore Co., 1200 Madison Ave. (6)
Martin, Loren H....2626 W. Washington St. (22)
Martz, Bill L.
Lilly Clinic, Marion Co. General Hospital (7)
Martz, Carl D.....912 Hume Mansur Bldg. (4)
Marvel, Robert J.....3426 N. Meridian St. (8)
Masbaum, Ned P.....1315 W. 10th St. (7)
Masters, John M.....805 Hume Mansur Bldg. (4)
Masters, Robert J. (S)
805 Hume Mansur Bldg. (4)
Matthew, W. Burleigh....518 Hume Mansur Bldg. (4)
Matthews, Bernard J.....4612 E. 10th St. (1)
Matthews, William M...1122 N. Bolton Ave. (19)
Maxam, B. T.....3524 N. Meridian St. (8)
Maxwell, Sam B.....Eli Lilly & Co.,
P. O. Box 618 (6)
Mealey, John, Jr.....I. U. Medical Center (7)
Megenhardt, Dennis S..1633 N. Capitol Ave. (2)
Meiks, Lyman T.....Riley Hospital (7)
Melin, John R.....1815 N. Capitol Ave. (2)
Mentendiek, Maurice H.
141 Buckingham Dr. (8)
Mericle, Earl W.....1633 N. Capitol Ave. (2)
Merritt, A. Donald.....I. U. Medical Center (7)
Merritt, Doris H.....I. U. Medical Center (7)
Mershon, Jack B.....3855 E. 10th St. (1)
Mertz, John H. O.....1711 N. Capitol Ave. (7)
Michael, Isaac E...2948 Kessler Blvd., N. Dr. (22)
Middleton, Harvey N.....1828 N. Illinois St. (2)
Millan, Felix....Marion Co. General Hospital (7)
Miller, Frank H.....201 Hume Mansur Bldg. (4)
Miller, Jerry A.....I. U. Medical Center (7)
Miller, Jerry R.....I. U. Medical Center (7)
Miller, John D.....Sunnyside Sanitorium (26)
Miller, L. Hoyt.....6000 E. 46th St. (26)
Miller, Roscoe E.....I. U. Medical Center (7)

Mitchell, George H...6049 E. Washington St. (19)
Moak, Glenn D.....712 Hume Mansur Bldg. (4)
Montgomery, William F.
904 Hume Mansur Bldg. (4)
Moore, Donald F...LaRue D. Carter Hospital (7)
Moore, Harold T.....5802 Allisonville Rd. (20)
Moran, William J.....1927 E. 62nd St. (20)
Morchan, Samuel.....3769 College Ave. (5)
Morgan, Margaret E....3400 N. Meridian St. (8)
Moriarty, John R.....5602 Madison Ave. (27)
Morrison, Lewis E...603 Hume Mansur Bldg. (4)
Morton, Joseph L.....St. Vincent's Hosp. (7)
Morton, Walter P.....3434 Fall Creek Blvd. (5)
Moser, Rollin H.....3524 N. Meridian St. (8)
Moss, Bobby L.....5316 E. 16th St. (19)
Moss, Harlan B.....1640 N. Ritter Ave. (18)
Moss, Herschel C.....1640 N. Ritter Ave. (18)
Mothersill, Mark H. (S)....3650 College Ave. (5)
Mouser, Robert W.....6201 Park Ave. (20)
Mullen, James B.....3120 N. Meridian St. (8)
Muller, Lullus P.....3120 N. Meridian St. (8)
Muller, Paul F.....3311 N. Meridian St. (8)
Muller, Victor H.....St. Vincent's Hosp. (7)
Murphy, Mary M.....1633 N. Capitol Ave. (2)
Myers, Charles W. (S)..R. R. 18, Box 256 (24)

N

Nagan, Robert F.....606 Hume Mansur Bldg. (4)
Nay, Richard M.....3524 N. Meridian St. (8)
Need, David J.....I. U. Medical Center (7)
Need, Louis T.....1927 S. Meridian St. (25)
Nester, Henry G.....1841 City-County Bldg. (4)
Nicholas, Dennis J.....4365 Wexford (26)
Nichols, William F.....5240 Fenmore Rd. (8)
Nie, Louis W.....2901 N. Meridian St. (8)
Nohl, John M.....457 N. Emerson Ave. (19)
Nolin, Richard T.....10447 N. College Ave. (80)
Nolting, Henry F. (S).....261 W. 40th St. (8)
Norman, William H...908 Hume Mansur Bldg. (4)
Norris, Max S.....510 Hume Mansur Bldg. (4)
Nourse, Myron H.....1711 N. Capitol Ave. (7)
Nugent, Edwin J...Allison Div. GMC, Box 894 (6)
Nurnberger, John I.....I. U. Medical Center (7)

O

O'Brian, Earl J.....3041 Lafayette Rd. (22)
Ochsner, Harold C., Jr.....5215 N. Illinois St. (8)
Ochsner, Harold C.....3440 N. Meridian St. (8)
O'Connell, Noreen M.
V. A. Hospital, 1481 W. 10th St. (7)
Offutt, Andrew C...Indiana State Board of Health, 1330 W. Michigan St. (7)
Olvey, Ottis N.....3769 Park Ave. (5)
Otten, Claude F.....812 C. of C. Bldg. (4)
Overley, Ross A.....1815 N. Capitol Ave. (2)
Overley, Toner M., Jr.....I.U. Medical Center (7)
Owen, John E.....605 Hume Mansur Bldg. (4)
Owens, Tracy C.....2823 N. Meridian St. (8)

P

Palmer, Charman F.....5398 Hillside Ave. (20)
Palmer, Harley P.....Methodist Hospital (7)
Palmer, Robert M.....I. U. Medical Center (7)
Palmer, Robert W.....5398 Hillside Ave. (20)
Pantzer, John G., Jr.....I. U. Medical Center (7)
Parker, George F., Jr..1502 N. Emerson Ave. (19)
Parker, John F.....1706 E. Washington St. (1)
Parker, Portia.....2226 W. Michigan St. (22)
Paskind, Jacob..Marion Co. General Hospital (7)
Paulissen, George T.....741 Markwood Ave. (27)
Pearson, John S...American United Life Ins. Co., 30 W. Fall Creek Parkway (6)
Peck, Franklin B., Jr.
Lilly Clinic, Marion Co. General Hospital (7)
Peck, Franklin B., Sr.....5833 Brockton Dr. (20)
Peirce, James D.
Eli Lilly & Co., 740 S. Alabama St. (6)
Permer, Erwin....635 Kessler Blvd., E. Dr. (20)
Peterson, Deward D.
Marion Co. General Hospital (7)
Petranoff, Theodore V. (S)
515 N. Tibbs Ave. (22)
Pettijohn, Fred L. (S).....2460 Central Ave. (5)
Pfaff, Dudley A.
V.A. Regional Office, 36 S. Pennsylvania St. (9)
Phillips, David L.....3400 N. Meridian St. (8)
Pickett, Robert D.....3524 N. Meridian St. (8)
Pierce, Raymond O., Jr.....3151 N. Illinois St. (8)
Pilcher, Jack E.....1802 N. Illinois St. (2)
Pontius, Edwin E.....Methodist Hospital (7)
Popplewell, Arvine G.
Marion Co. General Hospital (7)
Powell, Richard C.....I. U. Medical Center (7)
Price, Francis W.....1002 E. Troy Ave. (3)
Price, James O.....512 Hume Mansur Bldg. (4)
Price, Walter S.....8430 Washington Blvd. (40)
Pryor, Richard C.....6111 College Ave. (20)

Q

Quigley, Joseph B.....5470 E. 16th St. (18)

R

Rabb, Frank M.....3740 Central Ave. (5)
Rabb, Harry S.....3139 E. 10th St. (1)
Raber, Robert M.....1633 N. Capitol Ave. (2)
Rader, George S.....1815 N. Capitol Ave. (2)
Rafalski, Thomas A.....3120 N. Meridian St. (8)
Ragan, William D.....3400 N. Meridian St. (8)
Ralston, John D.....Central State Hosp. (22)
Ramsey, Frank B.....1802 N. Illinois St. (2)
Ransburg, Robert C.....Methodist Hospital (7)
Rapp, George F.....508 Hume Mansur Bldg. (4)
Rawls, George H.....3151 N. Illinois St. (8)
Reed, Philip B.....1815 N. Capitol Ave. (2)
Reed, Thomas E.....6049 E. Washington St. (19)
Rees, Russel C.....6114 E. Washington St. (19)
Reid, Charles A.....2445 Shelby St. (3)
Reisler, Simon (S)..310 Bankers Trust Bldg. (4)
Reitz, Lawrence A....340 White River Pkwy. (22)
Rice, Frederic A., Jr.....7017 Pendleton Pike (26)
Rice, Raymond D.....1010 E. 86th St. (40)
Rice, Raymond M.
Eli Lilly & Co., 740 S. Alabama St. (6)
Rice, Ronald B.....1010 E. 86th St. (40)
Rich, Richard B.....922 Hume Mansur Bldg. (4)
Richardson, Thad T.....513 S. Sherman Dr. (3)
Richter, Arthur B...720 Hume Mansur Bldg. (4)
Ridolfo, Anthony S.
Lilly Clinic, Marion Co. General Hospital (7)
Riley, Paul D.....Methodist Hospital (7)
Riner, Jack K.....5317 E. 16th St. (18)
Ritchey, James O.....608 Hume Mansur Bldg. (4)
Ritter, Wayne L.....404 Hume Mansur Bldg. (4)
Robb, John A.....238 Hume Mansur Bldg. (4)
Robertson, Ray B...6118 E. Washington St. (19)
Robinson, Earle U., Jr....2416 N. Capitol Ave. (8)
Rochlin, Isidore.....3202 N. Meridian St. (8)
Roesch, Ryland P.....5444 N. Illinois St. (8)
Roeske, Nancy A.....220 W. Beverly Dr. (8)
Rogers, Donald L.....3426 N. Meridian St. (8)
Rohn, Robert J.....I. U. Medical Center (7)
Roller, Charles W. (S).....915 Hervey (3)
Romberger, Floyd T., Jr. 3400 N. Meridian St. (8)
Rosenak, Bernard D...226 Hume Mansur Bldg. (4)
Rosenbaum, Irving, Jr. .....401 E. 34th St. (5)
Rosenberg, Gabriel J.....6450 W. 10th St. (24)
Ross, Alexander T.....I. U. Medical Center (7)
Roth, Bertram S.....6358 College Ave. (20)
Rougraff, Maurice E.
American United Life Ins. Co., 30 W. Fall Creek Parkway (6)
Row, D. Hamilton...906 Hume Mansur Bldg. (4)
Ruddell, Karl R. (S)...3202 N. Meridian St. (8)
Ruddell, Keith R.....3202 N. Meridian St. (8)
Rudesill, Cecil L. (S)
405 Hume Mansur Bldg. (4)
Rudesill, Robert L...405 Hume Mansur Bldg. (4)
Rushmore, Charles H.....240 N.Meridian St. (6)
Russell, John R.....1815 N. Capitol Ave. (2)
Rust, Byron K.....1547 W. 75th Pl. (60)

Rust, Roland B.....3939 Meadows Drive (5)
Ruth, Martin L.....4304 E. Washington St. (1)
Rutherford, Cyrus W. (S)
4601 N. Pennsylvania St. (5)
Ryan, C. David.....Methodist Hospital (7)
Ryan, Glen V.....2428 W. 16th St. (22)

S

Sage, Russell A.....1944 N. Capitol Ave. (2)
Salb, Max C.....823 C. of C. Bldg. (4)
Samter, Thomas G.....I. U. Medical Center (7)
Sanders, Fred.....6007 N. Michigan Rd. (8)
Sanders, Harry M. .....4829 E. 38th St. (18)
Sanders, Marilyn M.....Methodist Hospital (7)
Saperstein, Morris....1815 N. Capitol Ave. (2)
Schechter, John S.....3400 N. Meridian St. (8)
Scheier, Emil W.....1542 Prospect St. (3)
Schermer, Kenneth L.....Methodist Hospital (7)
Schiffer, Eva M.....Methodist Hospital (7)
Schlaegel, Theodore F., Jr.
I. U. Medical Center (7)
Schlegel, Donald M.....1815 N. Capitol Ave. (2)
Schmalhausen, Ansel W...1815 N. Capitol Ave. (2)
Schmidt, Loren F....605 Hume Mansur Bldg. (4)
Schmoyer, Maurice R...Community Hospital (19)
Schneider, Carl J.....1008 N. Beville Ave. (1)
Schneider, Paul A.....4829 E. 38th St. (18)
Schnute, Richard B.....I. U. Medical Center (7)
Schuchman, Gabriel.....3451 College Ave. (5)
Schuster, Dwight W.....1815 N. Capitol Ave. (2)
Schwarz, Anton
Pitman-Moore Co., 1200 Madison Ave. (6)
Scofield, John B.....3120 N. Meridian St. (8)
Scott, George E.....4110 Roland Rd. (8)
Scott, I. Winfield.....3400 N. Meridian St. (8)
Scott, John R.....6214 Broadway (20)
Scott, Robert P.....209 Hume Mansur Bldg. (4)
Scott, Samuel L.....6325 Guilford Ave. (20)
Seaman, Charles F...301 Hume Mansur Bldg. (4)
Searight, John L.....6032 E. 10th St. (19)
Sedam, Herbert L.....4548 College Ave. (5)
Segar, William E.....Riley Hospital (7)
Sellmer, George W.....1221 E. 86th St. (40)
Sexson, Hiram T.....3731 N. Keystone (18)
Seybert, Thomas C.....6000 E. 46th St. (26)
Shafer, Marion R...614 Hume Mansur Bldg., (4)
Shanafelt, Donald K.....1802 N. Illinois St. (2)
Shapiro, Burton J.....3620 N. Meridian St. (8)
Sheehan, Francis G..6049 E. Washington St. (19)
Shelley, Richard J.....5470 E. 16th St. (18)
Sherster, Harry.....1135 S. Meridian St. (25)
Shipley, Edward....LaRue D. Carter Hospital (7)
Shullenberger, Wendell A.
1815 N. Capitol Ave. (2)
Shumacker, Harris B., Jr.,
I. U. Medical Center (7)
Sicks, Okla W. (S).....607 E. 82nd St. (20)
Sidebottom, Earl W...507 Hume Mansur Bldg. (4)
Siderys, Harry.....3949 Meadows Dr. (5)
Siebe, Jack C.....4829 E. 38th St. (18)
Siersdorfer, Theodore N. (S)
5559 W. Morris St. (41)
Sigmond, Harvey W..321 Hume Mansur Bldg. (4)
Silver, Richard A.....712 Hume Mansur Bldg. (4)
Simmons, James E.....I. U. Medical Center (7)
Simms, J. Leon....2453 Northwestern Ave. (23)
Simpson, William D..6049 E. Washington St. (19)
Sims, J. Lawrence.....3949 Meadows Dr. (5)
Singco, Bienvenido.....5202 N. Illinois St. (8)
Slichenmyer, Jack E....1944 N. Capitol Ave. (2)
Slomka, Myron B.
Pitman-Moore Co., 1200 Madison Ave.,
P. O. Box 1656 (6)
Sluss, David H.....808 C. of C. Bldg. (4)
Smith, David L...2948 Kessler Blvd., N. Dr. (22)
Smith, E. Rogers (S).822 Hume Mansur Bldg. (4)
Smith, Francis C....1102 N. Irvington Ave. (19)
Smith, Roy Lee (S)...707 Underwriters Bldg. (4)
Sobat, William S.....Methodist Hospital (7)
Solomon, Reuben A. (S)
412 Hume Mansur Bldg. (4)
Soper, Hunter A.....3524 N. Meridian St. (8)
Souter, Martha C.....3360 N. Meridian St. (8)
Sovine, Joe W.....504 Hume Mansur Bldg. (4)
Spahr, John F., Jr.,....3440 N. Meridian St. (8)
Spalding, Joseph J...706 Hume Mansur Bldg.(4)
Sparks, Alan L.....1024 Hume Mansur Bldg. (4)
Spears, John M.....7046 Madison Ave. (27)
Speckman, Glenn H.....2120 E. 10th St. (1)
Spolyar, Louis W...Indiana State Board of Health,
1330 W. Michigan St. (7)
Sputh, Carl B., Jr.....301 Doctors' Bldg. (4)
Stadler, Harold E.....41 N. Shortridge Rd. (19)
Stander, Richard W.....I. U. Medical Center (7)
Stansbury, William E...3628 N. Sherman Dr. (18)
Stayton, Chester A., Jr.
313 Hume Mansur Bldg. (4)
Steinmetz, Edward F.
Marion Co. General Hospital (7)
Stephens, Donald E.....6211 College Ave. (20)
Stephens, Kuhrman H.
501 Hume Mansur Bldg. (4)
Stetson, John B.....I.U. Medical Center (7)
Stevens, Sydney L.....1802 N. Illinois St. (2)
Stoelting, Vergil K.....I. U. Medical Center (7)
Stone, Alvin T.....6202 College Ave. (20)
Stonier, Peter F.....3213 E. 36th St. (18)
Storey, D. Edmund.....6225 Broadway (20)
Storey, Joseph L.....3454 N. Illinois St. (8)
Storms, Roy B. (S).....812 C. of C. Bldg. (4)
Strang, William C.....1815 N. Capitol Ave. (2)
Streeter, Ralph T.....3131 E. 38th St. (18)
Strickland, James W.
Marion Co. General Hosp. (7)
Strickland, Neil R.....6000 E. 46th St. (26)
Stucky, Elsworth K.....1349 Madison Ave. (25)
Stump, Loyd K.....3949 Meadows Dr. (5)
Stump, Thomas A.
Marion Co. General Hospital (7)
Suelzer, John G.....1815 N. Capitol Ave. (2)
Suess, Robert E.....41 N. Shortridge Rd. (19)
Sullivan, James J.....St. Vincent's Hospital (7)
Summerlin, Jack D.....I. U. Medical Center (7)
Surratt, Mary Norris.....1010 E. 86th St. (40)
Sutton, William E....521 Hume Mansur Bldg. (4)
Swan, John R.....915 Hume Mansur Bldg. (4)
Switzer, Richard W.
Marion County General Hospital (7)
Symmes, Alfred T.....625 E. 38th St. (5)
Szynal, John S.....2811 E. 46th St. (5)

T

Takahashi, Masato.....I. U. Medical Center (7)
Talbott, Dan E.....1802 N. Illinois St. (2)
Tanner, Henry S.....321 Hume Mansur Bldg. (4)
Taube, Jack I.....214 Hume Mansur Bldg. (4)
Tavel, Morton E.....1815 N. Capitol Ave. (2)
Taylor, Clifford C.....Community Hospital (19)
Taylor, Frederic W.....3524 N. Meridian St. (8)
Teague, Frank W...1021 Hume Mansur Bldg. (4)
Teixler, Victor A.....224 Hume Mansur Bldg. (4)
Tepfer, Milton..Marion Co. General Hospital (7)
Test, Charles E.....1006 Hume Mansur Bldg. (4)
Teter, George V.....1221 E. 86th St. (40)
Tether, Joseph E.....510 Hume Mansur Bldg. (4)
Tharpe, Ray G.....3202 N. Meridian St. (8)
Thatcher, Hugh K., Jr....4548 College Ave. (5)
Thoman, Rex L.....I. U. Medical Center (7)
Thomas, Charles R.....4051 S. East St. (27)
Thomas, Edward P.....917 W. 30th St. (23)
Thomas, Fred A.....St. Vincent's Hospital (7)
Thomas, Lowell I.....1815 N. Capitol Ave. (2)
Thomas, Morris E.....1802 N. Illinois St. (2)
Thompson, John V.....7899 Ridge Rd. (40)
Thompson, Joseph F...6138 N. Hillside Ave. (20)
Thompson, Paul D.
423 Hume Mansur Bldg. (4)
Thompson, Wayne H.....5470 E. 16th St. (18)
Thornton, Harold C.....301 E. 38th St. (5)

Throop, Frank B.....3400 N. Meridian St. (8)
Tindall, George T.....6002 Windsor Dr. (18)
Tinsley, Frank W.....3044 Lafayette Rd. (22)
Tinsley, Walter B., Jr....3044 Lafayette Rd. (22)
Tinsley, Walter B. (S)....603 K. of P. Bldg. (4)
Tischer, E. Paul.....208 Hume Mansur Bldg. (4)
Tondra, John M.....400 Hume Mansur Bldg. (4)
Torrella, Jose A.....5324 W. 16th St. (24)
Toumey, Fred L.....1802 N. Illinois St. (2)
Townsend, James C.....I.U. Medical Center (7)
Trusler, H. Marshall...I. U. Medical Center (7)
Trusler, Harold M....408 Hume Mansur Bldg. (4)
Tuchman, Joseph H.....2040 E. 46th St. (5)
Tucker, Warren S...414 Hume Mansur Bldg. (4)
Tyler, Edward A.....I. U. Medical Center (7)
Tyner, Harlan H.....3202 N. Meridian St. (8)

U-V

Ullom, Ralph B.....3524 N. Meridian St. (8)
Van Denbark, Howard M..St. Vincent's Hosp. (7)
Vandivier, Robert M.....3715 N. Meridian St. (8)
Van Dorn, Myron J.....2165 Weslynn Dr. (8)
Van Fleet, Josephine....Indiana State Board of Health, 1330 W. Michigan St. (7)
Van Meter, C. Powell.....3419 E. 10th St. (1)
Van Tassel, Charles J., Jr.
709 Hume Mansur Bldg. (4)
Van Vactor, Helen D..226 Hume Mansur Bldg. (4)
Vellios, Frank.....I. U. Medical Center (7)
Vigor, David N.....Chrysler Corp., 2900 Shadeland Ave., (19)
Vollrath, Victor J.....5202 N. Illinois St. (8)
Von Der Haar, Gerard..4016 E. Michigan St. (1)
Vore, Robert E.....5470 E. 16th St. (18)

W

Wainscott, Clinton S., Jr..3120 N. Meridian St. (8)
Waldo, J. Thayer.....3989 Meadows Dr. (5)
Walters, Edward W.....4419 Park Forest Dr. (26)
Walther, Joseph E.....3202 N. Meridian St. (8)
Walton, William M.....1802 N. Illinois St. (2)
Ward, Wesley C.....3 E. 46th St. (5)
Warman, Alvah P. (S)....1363 E. 38th St. (5)
Warneke, Charles H.....I. U. Medical Center (7)
Warriner, James B...1012 N. Emerson Ave. (19)
Warvel, John H., Jr..614 Hume Mansur Bldg. (4)
Warvel, John H. (S)..4360 Kessler Blvd., N. D. (8)
Washington, Wilbert ....2142 N. Capitol Ave. (2)
Watring, Watson G.....I. U. Medical Center (7)
Wehrman, Jule O. (S)
1408 N. Pennsylvania St. (2)
Weigand, Clayton G.
Eli Lilly & Co., 740 S. Alabama St. (6)
Weinberger, Myron H.....I. U. Medical Center (7)
Weiss, Jason.....4914 W. 16th St. (24)
West, Joseph L.....6714 Rockville Rd. (24)
Westfall, B. Kemper.....2901 E. 38th St. (18)
Westfall, John B...1025 Hume Mansur Bldg. (4)
Wheeler, David E.....Community Hospital (19)
Wheeler, Edward C...313 Hume Mansur Bldg. (4)
White, Donald J.....3524 N. Meridian St. (8)
White, Douglas H.....3524 N. Meridian St. (8)
White, John P., Jr.....I. U. Medical Center (7)
Widdifield, G. E.....2614 Madison Ave. (3)
Wilbrandt, Hans R.....5324 W. 16th St. (24)
Wilkens, Irvin W.....1743 Shelby St. (3)
Williams, Charles D.....2422 Station St. (18)
Williams, Clifford L...Central State Hospital (22)
Williams, Harold W.....6000 E. 46th St. (26)
Williams, Howard S.....1815 N. Capitol Ave. (2)
Williams, Hugh L.....4829 E. 38th St. (18)
Williams, Paul D....Central State Hospital (22)
Wilson, Fred M.....I. U. Medical Center (7)
Wirey, Harold R.....6850 S. Madison Ave. (27)
Wise, William R.....2372 Lafayette Rd. (22)
Wishard, William N., Jr..1711 N. Capitol Ave. (7)
Woerner, Thomas E...620 Hume Mansur Bldg. (4)
Wolfram, Don J.....208 Hume Mansur Bldg. (4)
Wood, Donald E.....6325 Guilford Ave. (20)
Woodard, Abram S., Jr.....668 E. 38th St. (5)
Woolling, Kenneth R..718 Hume Mansur Bldg. (4)
Worley, Joseph P....5839 E. Washington St. (19)
Worley, Richard H.....5317 E. 16th St. (18)
Wrege, Malcolm L.....1502 N. Emerson Ave. (19)
Wright, James J.....1429 Shelby St. (3)
Wright, J. William, Jr.
301 Hume Mansur Bldg. (4)
Wunsch, Charles M.....I. U. Medical Center (7)
Wyttenbach, John E...503 Hume Mansur Bldg. (4)

Y

Yacko, Michael L.....5470 E. 16th St. (18)
Yingling, Robert J.....Community Hospital (19)
Young, James W.....6302 Guilford Ave. (20)
Young, John E.....4829 E. 38th St. (18)
Young, John M.....1456 E. 46th St. (5)
Young, John T.....3151 N. Illinois St. (8)

Z

Zell, Evertson H.....812 C. of C. Bldg. (4)
Zeman, Ruth E.....3400 N. Meridian St. (8)
Zeps, E. Frances.....Indiana State Board of Health, 1330 W. Michigan St. (7)
Zerfas, Phyllis K.....R. R. 1, Box 220 (27)

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Ley, Glen D.....1303 15th St., Bedford
Lewis, Robert J. 4350 Franklin Rd., Lawrence (26)
Asher, Ernest O. (S)
4730 W. 72nd St., New Augusta
Asher, James W...4730 W. 72nd St., New Augusta
Thurston, Harrison S. (S)
P. O. Box 411, North Webster
Paynter, Morris B.....59 Union St., Southport
Jacqmain, Ralph J.....609 DuBois St., Vincennes
Anderson, John T.....Pitman-Moore Co., 9550 Zionsville Rd., Zionsville
Harvey, Verne K., Sr...R. R. 2, Box 354, Zionsville

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Akre, Philip R...Brooks AFB, San Antonio, Texas
Allen, Donald R....603 E. Riverside Dr., Evansville
Baker, Charles R.....USPHS, Savannah, Ga.
Balch, James F., Jr.....St. Albans Naval Hospital, St. Albans, N. Y.
Barden, Tom P.....507 USAF Hosp., Kincheloe AFB, Mich.
Barrett, Robert V.....10474 Janice Lynn Circle, Cypress, Calif.
Beer, Alan E.....USPHS Indian Hospital, Tuba City, Ariz.
Bohner, Caryle B.....Huasca, Hidalgo, Mexico
Borden, Tom P.....507 USAF Hospital, Kincheloe AFB, Mich.
Brayton, John R., Jr.....USN Hospital, USN Aviation Med. Center, Pensacola, Fla.
Breneman, William L.....8654 Paint Trail Ct., Fort Worth, Texas
Brose, Paul E.....RCA BMEWS Project, Box 278, APO 23, New York, N. Y.
Bugh, Charles W.....1075 Riverview Dr., Fairbanks, Alaska
Close, Gerald A.....Mutambara Methodist Center, P. O. Mutambara, S. Rhodesia, Africa
Coddington, Robert C.....U. S. Army Hospital, Ft. Campbell, Ky.
Colbert, Richard M.....805 Alamanda Dr., Largo, Fla.
Colbert, Ruth E.....805 Alamanda Dr., Largo, Fla.
Cregger, Irby E.....1360 USAF Hospital, Orlando AFB, Fla.
Dehner, John R.....4500 USAF Hospital, Langley AFB, Va.
Dirks, Kenneth R.....U. S. Army Medical Unit, Ft. Detrick, Md.
Doss, Jerome F.....815 Medical Group, Forbes AFB, Kansas

Dyken, Paul R....3560 N. Pine Grove, Chicago, Ill.
Fisher, Gerald....Ippy, Central African Republic
Forry, Frank (S).....229 Pineville Rd., Spartanburg, N. Car.
Gabe, William E. (S).....61 Heather Lane, Orinda, Calif.
Gabrielsen, T. H.....%Salvation Army, International P.O. Box 1192, Seoul, Korea
Geisler, Hans E....Memorial Hospital for Cancer & Allied Diseases, Sloan-Kettering Inst., New York, N. Y.
Genna, Mary M.....11801 W. Indian Trail, Hale's Corners, Wisc.
Gilliland, John E.....Clinica Evangelica Morava, Ahuas, Dept. Gracias A Dios, Honduras, C. America
Hagman, Norman A.....32 Delafield Dr., Ft. Leonard Wood, Mo.
Haller, Carol A.....1260 Prospect Ave., No. 701, Milwaukee, Wisc.
Hull, DeWayne L.....Wilford Hall Hospital, Lackland AFB, San Antonio, Texas
Hurt, LaVerne B.....3102 Palm Ave., Delray Beach, Fla.
Kammen, Robert.....V. A. Hospital, Fresno, Calif.
Kenoyer, Wilbur L.....7520th USAF Hospital, APO 125, New York, N. Y.
Kurtz, Richard.....4302-6 O'Donnell Hdqrs., Ft. Riley, Kans.
Lawler, George F.....5226 Nautilus Dr., Cape Coral, Fla.
Lynch, William A..604 Aircraft & Warning Squad., APO 207, New York, N. Y.
McCarthy, Daniel F., Jr.....2nd Battalion, 34th Infantry, APO 112, New York, N. Y.
McConnaughey, Hal D.....U. S. Naval Hospital, Great Lakes, Ill.
McClain, C. R., Jr.....2137 Bending Willow Dr., Kettering, Ohio
Malcolm, Russell L., Jr.....Clinical Laboratory, Middletown Hospital, Middletown, Ohio
Mertz, Henry O., Sr. (S)...2911 Pharr Court, S., N. W., Atlanta, Ga.
Moore, Richard B.....931 St. Paul Ave., #9 St. Paul, Minn.
Murray, James S.....2068 Ventura Blvd., Camarillo, Calif.
Myers, Roy V. (S).....7710 Beta Circle, West Palm Beach, Fla.
Need, Richard L.....NINDB Research Center, Guam Memorial Hospital, Agana, Guam
Nelson, John W...Box 98, University of Tennessee, Memphis, Tenn.
Newman, Daniel M....USAF, Maxwell AFB, Ala.
Parks, Herbert E.....762 Cascade, Cincinnati, Ohio
Pearson, Lyman R.....1881 Ridgeway Dr., Clearwater, Fla.
Pittman, John N.....University Hospital, Ann Arbor, Mich.
Plott, Dwight M.....P. O. 83, Rogersville, Ala.
Poland, Maynard D.....25-D Lionel Ave., Waltham, Mass.
Rabb, Aaron....Veterans Hospital, Louisville, Ky.
Rhea, Kenneth E....Station Hospital, Mayport, Fla.
Rhodes, Theodore D.....R. R. 2, Box 1595, Nokomis, Fla.
Ricketts, Joseph W. (S).....136 Magnolia Dr., Orman Beach, Fla.
Rigg, John F. (S).....1279 N. E. 97th St., Miami Shores, Fla.
Robinson, Frank C. (S).....200 Via Mentone, Newport Beach, Calif.
Rogers, Thomas P.....6142 LaPintura Dr., La Jolla, Calif.
Rudolph, Stephen J., Jr....51st USAF Dispensary, APO 235, San Francisco, Calif.
Scheeringa, Ronald H....USPHS Hosp., 31st St. & Wyman Rd., Baltimore, Md.
Schuchman, Abe.7524 De Vista, Los Angeles, Calif.
Schumacher, Richard R.....360 Skylane Dr., Albany, Ga.
Smith, Stephen M....P. O. Box 362, Millbrook, Ala.
Snider, Byron...R. R. 1, Box 963, Escondido, Calif.
Spalding, David L.....USPHS Outpatient Clinic, Fourth and C Sts., S.W., Washington, D.C.
Spangler, John S.....3001 S. Parkway, Apt. 301, Chicago, Ill.
Steury, Ernest M.....Tenwek, Sotik, Bomet, Kenya, Africa
Talarico, Leonard H.....219 Orland Rd., Rochester 22, N. Y.
Trudgen, Spencer F....21st Evac. Hosp., Augsburg, Germany, APO 178, New York, N. Y.
Wasserman, Don H....121st Evac. Hosp., APO 20, San Francisco, Calif.
Ziperman, H. Haskell.....Medical Division, Hdqrs. USAREUR, APO 403, New York, N. Y.

## MARSHALL COUNTY

Hampton, James N.....Argos
Kelly, Frank H. (S).....Argos
Swihart, John J.....Argos
Connell, Vactor O.....Bourbon
Kemp, W. Alfred.....Bourbon

### Bremen

Bowen, Otis R.....424 W. South St.
Burket, Cecil R.....424 W. South St.
Cripe, Earl P.....119 N. Center St.
Schreiner, John E.....201 E. Plymouth
Stine, Marshall E.....424 W. South St.

### Culver

Baker, Milan D.....Culver Military Academy
Hippensteel, Russell R.....121 College Ave.
Howard, Joseph D.....921 Lake Shore Dr.
Reed, Donald W.....121 Mill St.
Rosero, Marciano A.....921 Lake Shore Dr.
Streeter, Ralph G.....Culver Military Academy

### Plymouth

Coursey, James O., Jr.....109 N. Walnut St.
France, Lloyd C.....1223 N. Center St.
Guild, John K.....1167 Pennsylvania
Kubley, James D.....304 N. Walnut St.
Peterson, Ronald L.....116 E. Washington St.
Reed, Robert G., Jr.....109 N. Walnut St.
Reno, Edward C.....700 Ferndale St.
Rimel, James F.....1223 N. Center St.
Robertson, James S.....304 N. Walnut St.
Vore, Louring W.....116 E. Washington St.

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Thompson, Alfred A. (S).....Tyner

## MARTIN COUNTY

(See Daviess-Martin)

## MIAMI COUNTY

Shrock, Ethan E.....Amboy
Crates, Gordon C.....Denver
Sixbey, Maurice D.....Denver
Malott, Fred R.....Converse
Sennett, William K.....Macy
Rendel, Harold E.....Mexico

### Peru

Carlson, Edward A. (S).....11½ W. Main St.
Ferrara, Donald W.....18 W. Fifth St.
Ferrara, Samuel J.....18 W. Fifth St.
Guthrie, James U.....331 W. Third St.
Herd, Cloyn R.....15 S. Wabash St.
Hill, Lloyd L.....65 N. Miami St.

Malouf, Stephen D. (S).....Box 639
Snyder, Parker W.....65 N. Miami St.

## MONROE COUNTY

(See Owen-Monroe)

## MONTGOMERY COUNTY

**Crawfordsville**

Alexander, Stephen J.....408 W. Market St.
Baird, Malcolm K.....411 Ben Hur Bldg.
Burks, Jess E.....411 Ben Hur Bldg.
Cornell, Robert A.....204 Ben Hur Bldg.
Daugherty, Fred N.....120 W. Pike St.
Dodds, Wemple.....Culver Hospital
Eggers, Richard R.....120 W. Pike St.
Haller, Thomas C.....411 Tinsley Ave.
Humphreys, John W.....312 Jones St.
Kirtley, James M.....416 Ben Hur Bldg.
Lingeman, Byron N.....419 Ben Hur Bldg.
Ludwig, Paul E.....306 Ben Hur Bldg.
Millis, Samuel C.....416 Ben Hur Bldg.
Peacock, Norman F.....219 Ben Hur Bldg.
Pierson, Robert H.....305 E. Main St.
Shannon, Wesley E.....408 W. Market St.
Viray, Victoriano G.....411 Tinsley Ave.
Wallace, Hawthorne C.....R. R. Donnelley Co.

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Priebe, Fred H. .....Marion Co. Gen. Hosp., Indianapolis
Blix, Fred M.....Ladoga
Davis, William H.....New Market
Holden, Gary R.....New Market
Kindell, Hurschell D.....New Richmond
Hales, Robert E.....Roachdale
Richards, Edgar E.....Russellville
Thompson, Claude N.....Waynetown
Parker, Carl B.....Wingate

## MORGAN COUNTY

**Martinsville**

Drake, Ellery T.....P. O. Box 110
Eisenberg, David A.....Sunnyside Dr.
Gray, Leon.....171 E. Washington St.
Miller, Ray D.....290 E. Washington St.
Ostheimer, George.....215 E. Washington St.
Pitkin, McKendree C.....440 Washington St.
Reese, Jay S.....Sunnyside Dr., P. O. Box 30
Van Wienen, John.....60 W. Morgan
Willan, Horace R. (S).....109 S. Jefferson St.
Winter, William P.....1390 E. Columbus

**Mooresville**

Comer, Kenneth E. .....R. R. 2, Box 444
Kendrick, William M.....130 Indiana St.
Kourany, Edgar.....320 N. Indiana St.
Kourany, Oscar.....320 N. Indiana St.
Van Bokkelen, Robert W.....320 N. Indiana St.

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Wilson, Oliver R.....Box 525, Morgantown
Miller, Robert J.....Paragon

## NEWTON COUNTY

Schoonveld, Arthur.....Brook
Parker, John C.....Goodland
Kresler, Leon E.....101 N. 4th St., Kentland
Yegerlehner, Roscoe S...103 N. 2nd St., Kentland
Guzman, Marcelino F...331 W. Beaver St., Morocco

## NOBLE COUNTY

Bowman, Charles M.....Albion
Nash, Justin R.....Albion
Greenlee, Joseph A., Jr.....Avilla
Sneary, Max E.....Avilla

**Kendallville**

Bryan, Robert E.....705 N. State St.
Gutstein, Richard R. (S).....120 Diamond
Hepner, Herman.....705 N. State St.
Lawson, Isaac H. (S).....125½ S. Main St.
Messer, Frank W.....115 E. Rush St.
Slough, Richard R.....115 E. Williams St.
Stallman, Carl F.....409 E. Wayne St.

**Ligonier**

Hooker, Donald J.....406 S. Main St.
Stone, Robert C.....401 S. Main St.
Stultz, Quentin F.....401 S. Cavin St.

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Slough, O. Thomas
4130 N. Kessler Blvd., Indianapolis (8)
Fipp, August L.....Rome City
Pulskamp, Bertrand H.....Wolcottville

## OHIO COUNTY

(See Dearborn-Ohio)

## ORANGE COUNTY

Hagan, Marion L.....French Lick
Keseric, N. E.....French Lick
Sugarman, Benjamin E.....French Lick
Hodgin, Phillip T.....Orleans
Schoolfield, William E.....Orleans
Clark, Ivan A.....Paoli
Manship, C. Stanley.....Paoli
McCalla, Charles X.....Paoli
Spears, John K.....Paoli

## OWEN-MONROE COUNTIES

**Bloomington**

Baxter, Neal E.....306 E. Fifth St.
Bidney, Evelyn B.....321 S. Jordan Ave.
Bomba, Brad J.....1920 E. Third St.
Booze, James H.....400 E. Third St.
Borland, Raymond M.....114 N. Lincoln St.
Buckingham, Richard E.....344 S. College Ave.
Byrne, Louis .....311 E. Fifth St.
Campbell, William T.....314 E. Seventh St.
Creek, Jean A.....1920 E. Third St.
Emery, Charles B., Jr.....400 E. Third St.
Farr, James C.....403 E. Fourth St.
Fowler, R. Ross.....104 N. Grant St.
Geiger, Dillon D.....115 S. Lincoln St.
Hardtke, Eldred F.....509 E. Fourth St.
Hepner, Herman S.....312 N. Walnut St.
Hibner, Kermit Q.....117 N. Grant St.
Holland, Deward J. (S).....313 N. College Ave.
Holland, Philip T.....108 W. Seventh St.
Holtzman, Paul W.....113 S. Lincoln St.
Houshmand, Cyrus.....422 E. Kirkwood Ave.
Hrisomalos, Frank N.....306 E. Kirkwood Ave.
Klein, Emanuel.....Indiana University
Link, William C.....314 W. First St.
Lundblad, Wilfred M.....1805 E. Tenth St.
Lyons, Robert E.....321 E. Fifth St.
McClary, Charles W.....1920 E. Third St.
McIntire, Clarence R.....Bloomington Hospital
Manifold, Harold M.....1920 E. Third St.
Marchant, Clarence H.....350 S. College Ave.
Mather, Glenn B.....Bloomington Hospital
Middleton, Thomas O.....400 W. Second St.
Milan, Joseph F.....311 E. Kirkwood Ave.
Owen, Margaret T.....200 S. Washington St.
Pizzo, Anthony.....Bloomington Hospital

Poolitsan, George C.....407 N. Walnut St.
Ramsey, Hugh S.....619 E. First St.
Ratts, L. D.....1920 E. Third St.
Rieger, I. Taylor.....102 N. Grant St.
Rogers, Otto F., Jr.....210 N. Washington St.
Rollins, Thomas K.....114 E. Seventh St.
Ross, Ben R.....314 E. Seventh St.
Ross, James B.....314 E. Seventh St.
Schell, H. Richard.....422 E. Kirkwood Ave.
Schilling, Richard J.....311 E. Kirkwood Ave.
Schultheis, Richard L.....916 Mitchell St.
Schuman, Edith B.....Indiana University
Seagle, William C.....111 E. Ninth St.
Sibbitt, Joseph W.....115 S. Lincoln St.
Smith, Herschel S.....110 S. Lincoln St.
Spencer, Beaufort A.....114 N. Lincoln St.
Stangle, William J.....640 S. Rogers
Taraba, Ralph W.....211 E. Martha St.
Topolgus, James N.....403 N. Walnut St.
Way, James A.....322 E. Kirkwood Ave.
Wenzler, Paul J.....311 E. Fifth St.
Wilson, Talmage L.....301 E. Kirkwood Ave.

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Stouder, Charles E.....P. O. Box 405, Ellettsville
Mitchell, George L. (S).....Smithville

**Spencer**

Brown, Marcel S.....53 W. Market St.
Kay, Oran E.....Main and Morgan Sts.
Roof, Roger S.....792 E. Morgan St.
Smith, Frederick R.....452 Lover's Lane

## PARKE-VERMILLION COUNTIES

Goodrum, William R.....Cayuga

**Clinton**

Evans, Frederick J.....242 S. Third St.
Gailey, Ivan L.....231 Walnut St.
Herzberg, Milton.....222 Elm St.
Kercheval, John M.....819 S. Third St.
Somerville, John W.....225 Elm St.

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Webb, Lawrence C.....Dana
Britton, Welbon D.....Montezuma
Minich, William G.....FMC Corp., Newport

**Rockville**

Beebe, Milton O., Jr.....110 York St.
Bloomer, Richard S.....115 N. Market St.
Dowell, Emil H.....Ohio St.
Harstad, Casper.....216 W. High St.
Kempf, Gerald F. (S).....Indiana State Hospital for Chest Diseases
May, William D.....Indiana State Hospital for Chest Diseases
Noblitt, James S. (S).....Rockville
Pirkle, Hubert B.....Indiana State Hospital for Chest Diseases

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Fell, Robert M.....Rosedale
Greene, Frederick G. (S).....Seelyville
Staff, Robert A...1239 S. Center St., Terre Haute
Pace, Jerome V.
210 N. Warman Ave., Indianapolis (22)

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White, Chester S. (S).....R. R. 2, Paris, Ill.
White, Isaac D. (S)
809 W. Broadway, Anaheim, Calif.

## PERRY COUNTY

Bush, Hargis R.....Cannelton

**Tell City**

Dukes, David A.....521 Main St.
Gilbert, Robert G.....Perry Co. Mem. Hosp.
Herr, John W. (S).....622 Main St.
James, Nicholas A. (S).....746 Ninth St.
Lohoff, Lewis C.....507 Main St.
Neifert, Noel L.....507 Main St.
Ress, Gene E.....507 Main St.
Smith, Fred, Jr.....507 Main St.

## PIKE COUNTY

**Petersburg**

Hall, Donald L.....7th & Poplar Sts.
Omstead, Milton.....110 S. Sixth St.

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DeTar, George B. (S).....Moore Haven, Florida
Higgins, James L.....608 Teefiezl Hospital, APO 83, New York, N. Y.

## PORTER COUNTY

**Chesterton**

Griffin, Joseph P.....Jackson Blvd.
Hall, Thomas C.....621 Broadway
Read, John E.....114 S. 11th St.
Robertson, William C.....600 E. Morgan

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Sun, Chen T.....Hebron

**Portage**

Carlson, Milton R.....14000 Central
Crise, John R.....14000 Central
Kilmer, Warren L.....14000 Central
Lands, Robert M.....14000 Central
Tetrick, Lain.....National Steel Corporation

**Valparaiso**

Brown, James C.....1005 Campbell St.
Covey, Thomas J.....1 Sheffield Dr.
Davis, Carl M.....202 Indiana Ave.
DeGrazia, Eugene J.....810 LaPorte Ave.
Dittmer, Jack E.....60 Jefferson St.
Dittmer, Thomas L.....23 Lincolnway
Frank, John R. (S).....23 Lincolnway
Gold, Marvin E.....1005 Campbell St.
Green, Leonard J.....1005 Campbell St.
Griffin, Charles G.....813 LaPorte Ave.
Koenig, Robert L.....810 LaPorte Ave.
Lee, Robert Y.....808 Lincolnway
Makovsky, Theodore.....1005 Campbell St.
Noonan, Leo C.....7 Napoleon St.
O'Neill, Martin J.....810 LaPorte Ave.
Sacks, Leonard Z.....Porter Memorial Hospital
Scheimann, Lois.....702 Lincolnway
Schmidt, Richard H.....Porter Memorial Hospital
Stoltz, Robert M.....501 Lincolnway
Vietzke, Paul C. F.....1005 Campbell St.
Wu, Stewart.....808 Lincolnway

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Gordon, Joseph L.....Wheeler

## POSEY COUNTY

Montgomery, Samuel B. (S).....Cynthiana
Woods, Arba L. (S)....25 S. E. Second St., #212, Evansville
Ropp, Harold E.....New Harmony
Boren, Paul R.....Poseyville
Boyle, Carroll L.....Poseyville

**Mount Vernon**

Challman, William B.....431 Walnut St.
Crist, John R.....105 E. Sixth St.
Hirsch, Herman L.....126 W. Fifth St.
Oliphant, Frank W.....701 Mulberry St.
Vogel, L. John.....131 W. Third St.

## PULASKI COUNTY

Eshelman, Henry R.....Monterey

**Winamac**

Carneal, Thomas E. (S).....111 N. Monticello
Halleck, Harold J.....119 W. Main St.
Hollenberg, Edward L.....210 S. Market St.
Thompson, William R.....111 N. Monticello

## PUTNAM COUNTY

Veach, Lester W.....Bainbridge
Veach, Richard L.....Bainbridge
Ellett, John, Jr.....Coatesville

**Greencastle**

Dettloff, Frederick R.....Alamo Bldg.
Johnson, James B.....105 E. Washington St.
Jones, Lawrence R.....250 Hillsdale Ave.
Lett, James C.....239 Hillsdale
Nichols, Anne Sackett.....707 E. Seminary St.
Schauwecker, Cleon M.....239 Hillsdale Ave.
Smith, A. Wilson.....DePauw University
Steele, Dick J.....Alamo Bldg.
Stephens, James P.....Alamo Bldg.
Thompson, Edward C.....Vine Street
Tipton, William R.....110 S. Vine St.
Wiseman, V. Earle.....239 Hillsdale Ave.

## RANDOLPH COUNTY

Nixon, Byron.....Farmland
White, Harvey E.....Farmland
Jordan, Leo E.....Lynn
Martin, Charles E. (S).....Lynn
Shallenberger, Henry R.....Modoc
Potter, Richard M.....Ridgeville

**Union City**

Birum, Patricia J.....334 W. Oak St.
Chambers, Carol R.....Chambers Medical Clinic
Chambers, Leroy B.....Chambers Medical Clinic
Landon, David J.....R. R. 2
McClure, Morris E.....334 W. Oak St.
Phipps, Leland K.....227 W. Oak St.
Reid, Robert W. (S).....726 W. Division St.
Wagoner, B. D.....Columbia and Lennox St.

**Winchester**

Dininger, William S.....303 S. Main St.
Engle, Russell B.....210 S. Main St.
Koch, Howard W.....208 E. Washington St.
Painter, Lowell W.....124 E. Franklin St.
Slick, Crystal R.....457 Elm St.
Sparks, Paul W.....214 S. Main St.

## RIPLEY COUNTY

Freeland, Bill E.....12 E. Boehringer, Batesville
Hisrich, Lloyd W...222 Maplewood Ave., Batesville
Paras, Jose L.....Batesville
Warn, William J.....Milan
Row, George S.....Osgood
Smith, R. Lee.....Osgood
McConnell, William C.....Sunman
Hopkins, L. H.....Versailles
Parker, John B. .....Versailles

## RUSH COUNTY

McNabb, George B. (S).....Carthage
Smith, Stephen D.....Knightstown
Sheets, Charles E.....Manilla
Worth, C. Willard.....Milroy

**Rushville**

Atkins, Clarence C.....225 N. Morgan St.
Corpe, Kenneth F.....R. R. #4
Dean, Donald I.....Fourth & Main
Ellis, Davis W., Jr.....E. 11th St.
Green, Frank H., Jr.....134 E. Second St.
Lee, John M. (S).....914 N. Morgan St.
McKee, Harry G.....208 W. First St.
Norris, Marvin G.....134 E. Second St.
Nutter, Wyndham H.....1003 N. Morgan
Schneider, Marvin C.....600 E. 11th St.

## ST. JOSEPH COUNTY

Zeitler, Philip S.....1400 Hudson St., Elkhart
Hartsough, Ralph I.....Lakeville

**Mishawaka**

Barone, Carmelo V.....307 W. Fourth St.
Christophel, Verna A.....109 W. Third St.
Farner, James E.....301 W. Fourth St.
Ganser, Richard A.....111 S. Race St.
Gerig, Eldon L.....303 S. Main St.
Goethals, Charles J.....602 Lincoln Way W.
Macri, Paul A.....116½ W. Third St.
Mahank, Camiel C.....303 S. Main St.
Malstaff, Comiel M.....113 S. Church St.
Orr, W. Robert.....303 S. Main St.
Reed, Robert F.....1316 Lincoln Way E.
Rosenwasser, Jacob.....225 Lincoln Way E.
Schaphorst, Richard A.....113 S. Church St.
Spalding, Wendell L.....427 Lincoln Way E.
Stringer, Drennon D.....303 S. Main St.
Templeton, Ames R.....522 Calhoun St.
Van Rie, Leo Paul (S).....116 S. West St.
Walerko, Frank M.....303 S. Main St.
Walters, Charles E.....319 S. Spring St.
Whitlock, Francis C.....110 N. Race St.
Whitlock, Merle E.....303 S. Main St.
Wurster, Herbert C.....221 E. Third St.
Zimmer, Henry J.....119½ Lincoln Way W.

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Luzadder, John E.
105 W. Michigan St., New Carlisle
Calvin, Helen M.....P.O. Box 38, North Liberty
Calvin, O. Walter.....P.O. Box 38, North Liberty
Hardy, John J. (S)...P.O. Box 23, North Liberty
Warrick, Homer L....106 Lincolnway W., Osceola
Helmen, Harry W. (S).....Rolling Prairie

**South Bend**

*(Zip Code 466 plus zone number.)*

A

Acker, Robert B. (S).....418 Sherland Bldg. (1)
Arisman, Ralph K.....607 Odd Fellows Bldg. (1)

B

Backs, Alton J.....1401 Lincoln Way (28)
Baran, Charles.....402 Sherland Bldg. (1)
Bartsch, Harvey L.
919 E. Jefferson Blvd., #102 (17)

Beach, Norman F.....919 E. Jefferson Blvd., #107 (17)
Bebensee, Donald L.....122 N. Lafayette (1)
Bechtold, S. E...919 E. Jefferson Blvd., #302 (17)
Bell, Horace D.....420 N. Hill St. (17)
Bell, Robert L.....531 N. Main St. (1)
Bennett, Jene R.....531 N. Main St. (1)
Berke, Robert D.....1118 Lincoln Way E. (18)
Biasini, Benedict A.....403 Dixie Way, N. (17)
Bickel, David A. (S)..515 Odd Fellows Bldg. (1)
Birmingham, Peter J. (S).426 Sherland Bldg. (1)
Bixler, Louis C. 919 E. Jefferson Blvd., #207 (17)
Bodnar, Leslie M.....525 N. Michigan (1)
Bogan, William C.....1512 Hass (15)
Booth, Franklin M.....430 Sherland Bldg. (1)
Borough, Lester D.....710 J. M. S. Bldg. (1)
Brechtl, Harvey J.
919 E. Jefferson Blvd., #104 (17)
Broghammer, Benjamin J.
919 E. Jefferson Blvd., #207 (17)
Buchanan, Wallace D.
919 E. Jefferson Blvd., #107 (17)
Buechner, Frederick W.
116 N. Main St., #261 (1)
Buslee, Roger M.....531 N. Main St. (1)
Bussard, Clifford F. (S)
202 Whitcomb-Keller Bldg. (1)
Bussard, Frank W.
202 Whitcomb-Keller Bldg. (1)
Butts, Milton A.....118 N. Walnut St. (28)

C

Carter, F. R. Nicholas (S)
2000 E. Jefferson Blvd. (17)
Cassady, James V.....815 Sherland Bldg. (1)
Cassady, John R.....815 Sherland Bldg. (1)
Chamblee, Roland W.
336 N. Notre Dame Ave. (17)
Clark, William H.....520 Sherland Bldg. (1)
Colip, George D.....514 Sherland Bldg. (1)
Colosey, Frederick J...3121 Mishawaka Ave. (15)
Cook, Gordon C.....719 N. Main St. (1)
Cooper, Harry L. (S)....410 Sherland Bldg. (1)
Cox, Alfred C.....51916 U.S. 31 N.
Culbertson, Carl S.....531 N. Main St. (1)
Custer, Edward W.....Healthwin Hosp. (17)

D

Davis, Edward A.....3014 Ardmore Trail (28)
Denham, Robert H..... 919 E. Jefferson Blvd., #204 (17)
DeVoe, Kenneth Roy....418 N. Michigan St. (1)
Dietl, Ernest L.....820 Sherland Bldg. (1)
Dingley, Albert F.
919 E. Jefferson Blvd., #204 (17)
Dodd, Robert D.....2311 N. Miami St. (14)
Dolezal, Bernard J.....115 S. Eddy St. (17)
Donnelly, Everett F.....527 N. Michigan St. (1)
Dunlap, D. Logan.....523 J.M.S. Bldg. (1)

E

Eades, R. Charles....914 E. Jefferson Blvd. (17)
Egan, Sherman L.....523 J.M.S. Bldg. (1)
Engel, Howard R.
919 E. Jefferson Blvd., #403 (17)
English, John Paul....120 N. Lafayette Blvd. (1)
Ericksen, Lester G.
919 E. Jefferson Blvd., #207 (17)
Erickson, Gustaf W...120 N. Lafayette Blvd. (1)

F

Feferman, Martin E.
919 E. Jefferson Blvd., #305 (17)
Feldman, Max.....1921 Miami St. (14)
Filipek, Walter J.....311 Odd Fellows Bldg. (1)
Firestein, Ben Z. 919 E. Jefferson Blvd., #307 (17)
Firestein, Ray.....416 Sherland Bldg. (1)
Fish, Edson C.....326 Sherland Bldg. (1)
Fisher, Lawrence F. (S)....1717 E. Colfax (17)
Foley, Hansel O.....704 N. Main St. (1)
Forrest, O. Norman, Jr.....719 N. Main St. (1)
Frank, Herbert.919 E. Jefferson Blvd., #202 (17)
Frank, Lyall L., Jr.....224 W. Navarre St. (1)
Frank, Lyall L.....224 W. Navarre St. (1)
Frash, DeVon W.....1910 Miami St. (14)
Frash, DeVon W., Jr.....1910 Miami St. (14)
Frey, William B.....316 N. Ironwood Dr. (15)
Friedman, Morris S.
919 E. Jefferson Blvd., #402 (17)
Frith, Louis G.....521 W. Washington Ave. (1)

G

Gaffney, Raymond.....535 W. Colfax Ave. (1)
Ganser, Ralph V.....302 Sherland Bldg. (1)
Gates, George E.....122 N. Lafayette Blvd. (1)
Gilman, Marcus M.....401 Odd Fellows Bldg. (1)
Godersky, George E.
919 E. Jefferson Blvd., #106 (17)
Graf, John Paul.....326 Sherland Bldg. (1)
Green, G. Richard.....822 Sherland Bldg. (1)
Green, George F.....822 Sherland Bldg. (1)
Green, Norval E.....704 N. Main St. (1)
Grillo, Donald.....226 Sherland Bldg. (1)
Grorud, Alton C.....120 N. Lafayette Blvd. (1)
Grove, James H. 919 E. Jefferson Blvd., #107 (17)

H

Haley, George M.....424 Sherland Bldg. (1)
Haley, Paul E.....816 Sherland Bldg. (1)
Hall, James M.....914 E. Jefferson Blvd. (17)
Hamilton, Charles O.....527 N. Michigan St. (1)
Hanley, Harriet Faith
919 E. Jefferson Blvd., #101 (17)
Haugseth, Ellsworth K.
122 N. Lafayette Blvd. (1)
Hawkins, Glen E.....527 N. Michigan St. (1)
Helmer, John F.....826 Sherland Bldg. (1)
Hilbert, John W. (S)
410 W. Washington Ave. (1)
Hildebrand, John O., Jr...1307 E. Ewing Ave. (14)
Hill, Theodore A.....107 N. Eddy St. (17)
Hill, Wallace C.
919 E. Jefferson Blvd., #306 (17)
Holdeman, Lillian S.....228 S. St. Joseph St. (1)
Holdeman, Richard W..404 N. Lafayette Blvd. (1)
Holtzman, Norman N...3123 S. Michigan St. (14)
Houser, D. Stanley.....2314 Miami (14)
How, Louis E.....1419 S. Michigan St. (13)
Hyde, Carroll C. (S)..120 N. Lafayette Blvd. (1)

J-K

Jankowski, Ernest B...411 S. Sheridan Ave. (19)
Johns, Nicholas C.....116 E. Jefferson (1)
Kamm, Bernard A.....526 Sherland Bldg. (1)
Karn, John W.....326 Sherland Bldg. (1)
Kieffer, William J.....919 E. Jefferson Blvd. (17)
Knapp, Arthur L. (S).2215 Mishawaka Ave. (15)
Knode, Kenneth T.....729 Sherland Bldg. (1)
Krueger, John E.....326 Sherland Bldg. (1)
Kuhn, Frederick L.....1215 S. Michigan St. (18)

L

Lamb, J. Leonard.....825 Sherland Bldg. (1)
Lane, William H.....418 N. Michigan St. (1)
Lester, Vern L..919 E. Jefferson Blvd., #107 (17)
Levatin, Bernard I.
919 E. Jefferson Blvd., #303 (17)
Levkoff, Abner H.....919 E. Jefferson Blvd., #101-03 (17)

Lionberger, John R.
919 E. Jefferson Blvd., #207 (17)
Liss, Emanuel C.....119 S. Eddy St. (17)
Lockhart, Philip B.
919 E. Jefferson Blvd., #107 (17)

M

MacDonell, Eldred H...122 N. Lafayette Blvd. (1)
McCraley, William J.....218 S. Francis (17)
McDonald, Ralph M.....502 J.M.S. Bldg. (1)
McFarland, Corley B...122 N. Lafayette Blvd. (1)
McMeel, James.....1138 Whitehall Dr. (15)
Marquis, Gordon.....120 N. Lafayette Blvd. (1)
Martinov, William E.
919 E. Jefferson Blvd., #301 (17)
Mason, Bernard A.....120 N. Lafayette Blvd. (1)
Mauzy, Merritt C.....919 E. Jefferson Blvd. (17)
Metcalfe, Grant E.
919 E. Jefferson Blvd., #308 (17)
Miller, Milo K. (S)..122 N. Lafayette Blvd. (1)
Mott, Cassell A...1301½ W. Washington St. (16)
Mueller, Hilbert M....120 N. Lafayette Blvd. (1)
Murphy, Eugene C....122 N. Lafayette Blvd. (1)
Murphy, Josephine F.....111 W. Bartlett St. (1)

N-O

Neher, John L.....17615 State Rd. #23
Nelson, F. Dale.....704 N. Main St. (1)
Nelson, Raymond E.....206 E. Bartlett St. (1)
Olson, Donald T. 919 E. Jefferson Blvd., #309 (17)
Olson, Kenneth L.....919 E. Jefferson Blvd., #207 (17)
Oren, William F.....919 E. Jefferson Blvd., #301 (17)

P

Pairitz, Frank D.....60649 U. S. 31 S. (14)
Parsons, Robert.....919 E. Jefferson Blvd. (17)
Pascuzzi, Chris A.....531 N. Main St. (1)
Pauszek, Thomas B...704 W. Washington St. (6)
Petrass, Andrew (S).....516 Sherland Bldg. (1)
Phelps, Stephen R.....818 Sherland Bldg. (1)
Plain, George.....122 N. Lafayette Blvd. (1)
Proudfit, Charles H.
919 E. Jefferson Blvd., #304 (17)
Pyle, Harold D.....119 S. Eddy St. (17)

R

Rasmussen, Ruth F...122 N. Lafayette Blvd. (1)
Rigaux, Armand J.....816 Odd Fellows Bldg. (1)
Rigley, Edward L.....408 Sherland Bldg. (1)
Roberts, Billy J.....3123 Mishawaka Ave. (15)
Rodin, Herman H.....822 Oak Ridge Dr. (17)
Rosenheimer, George M...418 N. Michigan St. (1)
Rubens, Eli.....2314 Miami (14)
Rudolph, Carl J.....110 W. Bartlett St. (1)

S

Sanderson, Robert B.....730 Sherland Bldg. (1)
Sandock, Louis F.....503 Sherland Bldg. (1)
Sandoz, Harry H.....612 Odd Fellows Bldg. (1)
Schiller, Herbert A.
919 E. Jefferson Blvd., #205 (17)
Scott, Frank M.....122 N. Lafayette Blvd. (1)
Selby, Keith E.....407 Lincoln Way W. (1)
Sellers, Francis M.....814 Oak Ridge Dr. (17)
Sharp, Merle C.....717 N. Main St. (1)
Shelley, Edward S.....207 S. Taylor St. (25)
Shriber, William H...122 N. Lafayette Blvd. (1)
Shriner, Richard Lee
919 E. Jefferson Blvd., #308 (17)
Sisson, Norvel D.....531 N. Main St. (1)
Skillern, Penn G. (S).....1014 E. Fox St. (14)
Skillern, Scott D.....422 Sherland Bldg. (1)
Slominski, Harry H. (S)
708 Odd Fellows Bldg.(1)
Sobol, Zbigniew W.....525 N. Michigan St. (1)
Spenner, Raymond W.....726 Sherland Bldg. (1)
Staunton, Henry A.....3016 Mishawaka Ave. (15)
Stiver, Daniel D.....822 Sherland Bldg. (1)
Stogdill, William J.....318 Sherland Bldg. (1)
Stratigos, Joseph S.....527 N. Lafayette Blvd. (1)

T

Thompson, John M.....305 Sherland Bldg. (1)
Thompson, Robert A.
913 S. Twyckenham Dr. (15)
Thornton, Maurice J.
919 E. Jefferson Blvd., #107 (17)
Tirman, Wallace S.
919 E. Jefferson Blvd., #207 (17)
Traver, Perry C. (S)....1010 Riverside Dr. (16)

V-W-X-Y-Z

Vagner, S. Bernard....2201 Lincoln Way W. (8)
VanFleit, William E.
919 E. Jefferson Blvd., #407 (17)
Vurpillat, Francis J...132 N. Lafayette Blvd. (1)
Wack, James E.....530 W. Indiana Ave. (14)
Walker, Edwin M., Jr.....326 Sherland Bldg. (1)
Ward, James W.....325 Wakewa (17)
Weiss, Eugene.....919 E. Jefferson Blvd. (17)
White, Donald G.....1815 Ireland Rd. (14)
Wilhelm, Agatha M..1032 E. Wayne at Eddy (17)
Wilson, James M.....919 E. Jefferson Blvd. (17)
Wixted, John F...919 E. Jefferson Blvd., #1 (17)
Wixted, Julia L...919 E. Jefferson Blvd., #1 (17)
Zeiger, Irvin L.....3123 Mishawaka Ave. (15)

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Blackburn, Erwin
Beatty Memorial Hosp., Westville
Hillman, Marion W.....Box 473, Westville
Cline, Kenneth L.....Box 57, Wyatt

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Bassler, Carl R. (S).....R. R. # 4, Niles, Mich.
Fish, Clyde M. (S)
R. R. # 2, Edwardsburg, Mich.
Martin, Charles F., Jr.....611-67th Ave., N.E., Minneapolis, Minn.
Edwards, Bernard E...1102 Harmon, Tacoma, Wash.
Smith, Lee, Jr.....Castaner Hospital, Castaner, Puerto Rico

## SCOTT COUNTY

Bogardus, Carl R.....61 Main St., Austin

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Castro, Ignacio B., Jr....685 Wanda St., Scottsburg
McClain, Marvin L.....935 First St., Scottsburg
Sabens, James A.....69 Wardell St., Scottsburg

## SHELBY COUNTY

Nigh, Rufus M.....Fairland
Davis, John A.....Flat Rock

### Shelbyville

Arata, Lucian A..... 327 W. Broadway
Dalton, Wilson L.....117 W. Washington St.
Deupree, William D.....23 W. Hendricks St.
Green, William L.....103 W Washington St.
Inlow, Herbert H.....103 W. Washington St.
Inlow, Paul M.....103 W. Washington St.
Inlow, Robert P.....103 W. Washington St.
Inlow, William D. (S)....103 W. Washington St.
Miller, Richard C.....17 W. Mechanic St.
Moheban, Joseph.....120 W. Jackson St.
Paz, Luis.....526 E. McKay Rd.
Richard, Norman F.....103 W. Washington St.

Scott, V. Brown.....103 W. Washington St.
Silbert, David B.....17 S. Tompkins
Spindler, Robert D.....165 W. Mechanic St.
Tindall, William R.....505 S. Harrison St.
Tower, James H., Jr.....124 W. Franklin St.
Whitcomb, Roger F.....120 W. Jackson St.

## SPENCER COUNTY

Medcalf, Norman L. (S).....Lamar
Jolly, Wesley P. (S).....Richland
Glackman, John C., Jr.
6th and Main Sts., Rockport
Monar, Michael.....6th and Main Sts., Rockport

## STARKE COUNTY

Leinbach, Earl R.....Hamlet

**Knox**

DeNaut, James F.....4 N. Heaton St.
Henry, Howard J.....107 S. Main St.
Ingwell, Guy B.....201 S. Heaton St.
McClure, Clark.....107 S. Main St.
Palmer, W. Allen.....107 S. Main St.

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Llamas, Dominador F. 520 Lane St., North Judson

## STEUBEN COUNTY

**Angola**

Artz, Richard W.....416 E. Maumee
Barton, Robert.....625 S. Superior St.
Cameron, Don F.....416 E. Maumee
Cameron Mary H.....416 E. Maumee
Crum, Marion M.....301 E. Maumee
Davis, Claude E.....909 W. Maumee
Hartman, John J.....909 W. Maumee
Kissinger, Knight L.....411 E. Gilmore
Mason, Donald G.....416 E. Maumee
Rausch, Norman W.....416 E. Maumee

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McCormack, Lloyd L.....Fremont
Schrepferman, Wayne.....Hamilton

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Yocum, Paul S., Sr.....4826 Alhambra Circle, Coral Gables, Florida

## SULLIVAN COUNTY

Brown, John S.....Carlisle
Whipps, Charles E. (S).....Carlisle
Dukes, Betty.....Dugger
Dukes, Frederic M. (S).....Dugger
Dukes, Joe E.....Dugger
Bethea, Robert O.....Farmersburg
Hernandez, Antonio.....Shelburn

**Sullivan**

Bedwell, Marion H.....16 N. Court St.
Crowder, James H.....112 N. Section St.
Eskew, Kenneth W.....117 W. Washington St.
McClure, Glen.....342 S. Main St.
Maple, James B. (S).....117 W. Washington St.
Scott, Irvin H.....117 W. Washington St.

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Daugherty, William L.....Hutsonville, Ill.
Taylor, John R.....105 N. Main, Palestine, Ill.

## SWITZERLAND COUNTY

(See Jefferson-Switzerland)

## TIPPECANOE COUNTY

Derhammer George L.....Brookston
Gish, Howard M.....Brookston
Dublin, Madeline P.....Francesville

**Lafayette**

Ade, Charles H.....2211 South St.
Ade, Mary Keller.....2211 South St.
Baker, John R.....1727 Perrine
Balkema, Catherine M.....3 N. 18th St.
Bayley, William E.....2400 South St.
Beuerman, V. A. .....2600 Greenbush St.
Bolin, Robert C.....2600 Greenbush St.
Bridge, Barton C.....Jefferson Square
Buhrmester, Harry C.....2600 Greenbush St.
Burns, John T.....5 N. 25th St.
Bush, Jack A.....405 Life Bldg.
Calvert, Raymond R.....314 N. Sixth St.
Canganelli, Vincent G.....2433 S. Ninth St.
Carpenter, James B.....15 N. 25th St.
Cole, Ira.....2315 South St.
Coyner, Alfred B. (S).....509 Life Bldg.
Davis, Grayson B.....2211 South St.
Davis, Howard B.....2600 Greenbush St.
Deur, Julius J.....1011 Columbia
Donahue, George R.....718 Life Bldg.
DuBois, Ramon B.....23 N. 25th St.
Eaton, Marion J.....214 Life Bldg.
Elliott, Paul W.....35 N. 25th St.
Engeler, James E.....2600 Greenbush St.
Ferguson, William B.....2525 South St.
Fields, Don C.....2600 Greenbush St.
Flack, Russell A.....1005 Life Bldg.
Fox, Richard F.....2600 Greenbush St.
Frasch, Mahlon G.....300 Life Bldg.
Frey, Harley H., Jr.....405 Life Bldg.
Gery, Richard E.....2600 Greenbush St.
Gripe, Richard P.....2600 Greenbush St.
Haas, Charles F.....2211 South St.
Hannemann, Robert E.....2600 Greenbush St.
Harden, Murray E.....903 Life Bldg.
Harter, Eli B.....2600 Greenbush St.
Harvey, Bennett B.....35 N. 25th St.
Heid, George J., Jr.....35 N. 25th St.
Herrold, George W.....2 N. 26th St.
Holladay, Lloyd J.....411 Life Bldg.
Horswell, Richard R.....2600 Greenbush St.
Hughes, Anson F.....2424 Ferry St.
Hughes, Richard R.....31 N. 25th St.
Hull, James E.....2211 South St.
Hunsberger, Walter G.....2600 Greenbush St.
Hunter, Frank P. (S).....617 Life Bldg.
Johnson, Herbert S.....2600 Greenbush St.
Johnson, Lowell R.....2522 South St.
Jones, David M.....24 N. 24th St.
Karberg, Richard J.....2420 Ferry St.
Klatch, Ben Z.....2211 South St.
Klepinger, Harry E.....724 Life Bldg.
Kohne, Robert W.....3010 Underwood
Kuipers, Fred M.....2600 Greenbush St.
Landis, Charles B.....2211 South St.
Loop, Frederick A.....914 Life Bldg.
McAdams, Hugh B.....2011 Kossuth St.
McAdams, Robert.....2011 Kossuth St.
McClelland, Donald C. (S)..1021 Highland Ave.
McFadden, James M.....35 N. 25th St.
McKinley, Joseph.....312 Life Bldg.
McKinney, Daniel H.....301 Life Bldg.
McPherson, Richard C.....2600 Greenbush St.
Marsh, George W.....1216 Howell
Marvel, Howard R.....2600 Greenbush St.
Mather, Charles R.....2600 Greenbush St.
Mather, Robert L.....609 Life Bldg.
Miller, Albert J.....35 N. 25th St.
Miller, Roland E.....2200 Scott St.
Miller, William J.....2600 Greenbush St.
Mount, William M.....20 N. 24th St.

Neumann, Kenneth O.....618 Life Bldg.
Onorato, Joseph J.....2433 S. Ninth St.
Peyton, Frank W.....2424 Ferry St.
Pickerill, James M.....301 Life Bldg.
Ratcliff, Frank W.....405 Life Bldg.
Ricchetti, Warren F.....3134 Longlois Dr.
Riggs, Wendell A.....2600 Greenbush St.
Rothrock, Philip W.....2200 Scott St.
Ruschli, Edward B. (S).....510 Life Bldg.
Russell, Henry T.....St. Elizabeth Hospital
Shively, John L.....2525 South St.
Sholty, William M.....405 Life Bldg.
Smith, Lowell C.....637 Ferry St.
Stahl, Edward T.....2600 Greenbush St.
Steele, Hugh H.....2600 Greenbush St.
Strayer, Joseph W.....612 Life Bldg.
Stuntz, Edgar C.....Wabash Valley Hospital
Trout, Carl J.....314 N. Sixth St.
Tubbs, George R. (S).....2502 Iroquois Trail
Underwood, George M.....Jefferson Square
Van Buskirk, Edmund L.....2600 Greenbush St.
Van Den Bosch, Wallace R.....2216 South St.
Vermilya, Robert W.....405 Life Bldg.
Wagner, Anabel.....405 Life Bldg.
Wagner, Lindley.....Jefferson Square
Waits, Chester L.....15 N. 25th St.
Webster, Paul L.....2600 Greenbush St.
Weller, Wendell A.....2600 Greenbush St.

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Wong, Norman F.....Linden
Peterson, Joel A.....R. R. 5, Monticello
Babb, Forrest J.....Stockwell

**West Lafayette**

Ash, Harold H.....712 Bexley Rd.
Bahler, Dean R.....104 Mohawk Lane
Carpenter, Robert S.....207 North St.
Carroll, Bertha Rose.....1125 Glenway
Crockett, Franklin S. (H).....424 Littleton St.
Fitzgerald, Brice E.....Purdue Health Center
Hass, Caroline E.....402 Northwestern Ave.
Hass, Thomas W.....402 Northwestern Ave.
Keplinger, James E.....402 Northwestern Ave.
Martin, Joe M.....2900 N. River Rd.
Meikle, Louise J. (S).....606 Terry Lane
Roller, Mac C.....400 N. River Rd.
Rommel, Clarence H.....456 Northwestern
Schmiedicke, Paul H.....Purdue University
Spurlock, Fae H.....Purdue Health Center
Van Kirk, John R.....724 Northwestern Ave.
Wilms, John H.....Purdue University

## TIPTON COUNTY

Haller, Robert L.....Kempton
Stouder, Albert E.....Kempton
Tranter, William F.....Sharpsville

**Tipton**

Burkhardt, Boyd A.....202 S. West St.
Carter, Jean V.....130 N. Main St.
Compton, George L.....219 N. Independence
Gossard, Meredith B.....308 N. Independence
Kincaid, Raymond K.....202 S. West St.
Kurtz, William A.....202 S. West St.

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Ericson, Harold L.....Windfall
Moser, Elmer B. (S).....Windfall

## UNION COUNTY

**(See Wayne-Union)**

## VANDERBURGH COUNTY

*(Zip Code 477 plus zone number.)*

**Evansville**

A

Acre, Robert R.....706 Walnut St. (8)
Adler, Raymond N.....714 Second Ave. (10)
Adye, Wallace M., Jr...1307 N. Stringtown Rd. (11)
Alexander, John E.....7720 Lauderdale Dr. (15)
Anderson, Milton H...Evansville State Hosp. (2)
Antes, Earl H.....420 Cherry St. (13)
Arendell, Robert E.....1400 Cass Ave. (14)
Austin, Eugene W.....3700 Bellemeade (15)

B

Baker, Herman M. (S).....715 First Ave. (10)
Baker, Mason R.....1008 S. Evans Ave. (13)
Barnhart, Willard T.....701 Chestnut St. (13)
Beck, Robert E.....600 Mary St. (10)
Begley, Joseph W., Jr. 314 S. E. Riverside Dr. (13)
Beisel, Larry H.....420 Cherry St. (13)
Bender, Martin J.....912 Hulman Bldg. (8)
Bennett, Abner P.....412 S. E. Fourth St. (13)
Bissonnette, Roger P.....420 Cherry St. (13)
Bloss, Bryant A.....715 First Ave. (10)
Boone, Robert D.....420 Cherry St. (13)
Boswell, Robert W. C.....2351 Division St. (14)
Boyd, Stella N.....502 Hulman Bldg. (8)
Brakel, Frank J., Jr.....420 Cherry St. (13)
Britt, Robert L.....420 Cherry St. (13)
Brockmole, Arnold W...201 S. E. Third St. (13)
Brooks, Edwin A.....214 Indiana Bank Bldg. (8)
Brown, George W.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Bryan, Stanton L.....607 Hulman Bldg. (8)
Buddrus, David J.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Buehner, Donald F.....3700 Bellemeade (15)
Burger, Thomas C.....3700 Bellemeade (15)
Burnikel, Ray H.....527 Sycamore St. (8)
Burress, Clyde R.....723 Mary St. (10)

C

Cacia, John J.....402 S. E. Seventh St. (13)
Carlson, Ralph F.....517 Sycamore St. (8)
Cates, Jeryl R.....647 Plaza Dr. (15)
Clark, Thomas W.....420 Cherry St. (13)
Clouse, Paul A.....613 S. Weinbach Ave. (14)
Cockrum, William M.....908 Hulman Bldg. (8)
Coleman, Joseph E.....3700 Bellemeade (15)
Combs, Herman T.....807 W. Indiana (10)
Combs, John H.....412 S. E. Fourth St. (13)
Cooper, Waller W.....Deaconess Hospital (10)
Corcoran, Patrick J. V.....3700 Bellemeade (15)
Crawford, James H.....221 Chestnut St. (13)
Crevello, Albert J.....3700 Bellemeade (15)
Crimm, Paul D.....Boehne Hospital (12)
Crudden, Charles H...Clearview Sanitarium (10)
Cullnane, Chris W.....2312 W. Franklin St. (12)

D

Daves, W. Lawrence.....715 First Ave. (10)
Davidson, Harold H.....420 Cherry St. (13)
Davis, Max D.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Deems, Myers B.....314 S. E. Riverside Dr. (13)
Denzer, Edward K.....108 S. E. Third St. (8)
Denzer, William O.....923 Bellemeade (13)
Dieckman, Herbert S.....3700 Bellemeade (15)
Dodd, Roberts K.....2042 Lincoln Ave. (14)
Downer, Luther H.....521 Oak Street (13)
Drake, Dale W.....St. Mary's Hospital (10)
Durkee, Melvin S.....3700 Bellemeade (15)

Durkin, John W., Jr.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Dycus, Walter A.....319 N. St. Joseph Ave. (12)
Dyer, Wallace K.....3700 Bellemeade (15)

E

Ebin, Judah L.....101 S. E. Third St. (8)
Eisterhold, John A...5300 New Harmony Rd. (12)
Engel, Edgar L.....126 S. E. Seventh St. (8)
Ewer, Robert W.....420 Cherry St. (13)

F

Faith, Ira L.....805 Old Nat'l. Bank Bldg. (8)
Faul, Henry J.....815 Hulman Bldg. (8)
Faw, Melvin L.....420 Cherry St. (13)
Fenneman, Robert J.....402 S. E. Seventh St. (13)
Fickas, Dallas.....807 S.E. First St. (13)
Fisher, William C.....715 First Ave. (10)

G

Garland, Edgar A.....606 S. Weinbach (14)
Garst, Garland R.....3700 Bellemeade (15)
Gaul, L. Edward.....509 Hulman Bldg. (8)
Geller, Samuel.....R. R. 8, Box 143A (11)
Getty, William H.....420 Cherry St. (13)
Giorgio, Douglas J.....916 S. Burkhardt Rd. (15)
Gourieux, E. De Verre.....3700 Bellemeade (15)
Greenburg, Louis T.....2301 W. Michigan St. (12)
Griep, Arthur H.....5414 Madison Ave. (15)
Grimm, William C. H., Jr.....420 Cherry St. (13)
Guckien, Joseph L.....715 First Ave. (10)

H

Hammond, R. Case.....701 Chestnut St. (13)
Hare, Daniel M.....7800 Taylor (15)
Harlan, William L.....3700 Bellemeade (15)
Harned, Ben K., Jr.....420 Cherry St. (13)
Harris, Robert L.....4 Woodmere Lane (11)
Hart, L. Paul.....3700 Bellemeade (15)
Hartley, Clarence A., Jr...221 Chestnut St. (13)
Hartz, F. Minton.....123 S. E. Second St. (8)
Hassel, Walter B.....1905 E. Division St. (14)
Heard, Albert.....322 E. Cherry St. (13)
Heinrich, Weston A...314 S. E. Riverside Dr. (13)
Hendershot, Eugene L...412 S. E. Fourth St. (13)
Hermayer, Stephen....220 S. E. Seventh St. (13)
Herrmann, Gordon T.....3700 Bellemeade (15)
Herzer, Clarence C.....322 N. Fulton (10)
Himebaugh, Gilbert J.....115 N. Weinbach (11)
Hobbs, Arthur A.....600 Mary St. (10)
Hobgood, James L., Jr....6400 Jefferson Ave. (15)
Hoopes, Jane M.....3700 Bellemeade (15)
Hoover, J. Guy.....517 Sycamore St. (8)
Hovda, Richard B.....St. Mary's Hospital (15)
Huggins, Victor S.....715 First Ave. (10)
Hyatt, Gilbert T.....1106 W. Franklin St. (10)

J

Johnson, Victor.....2301 W. Michigan St. (12)
Johnson, Stephen L.....521 Sycamore St. (8)

K

Kauffman, Harley M.....219 Walnut St. (8)
Kelly, John B.....420 Cherry St. (13)
Kessler, Robert B.....1338 Division St. (14)
Kiechle, Frederich L.....726 S. E. First St. (13)
Kimmel, George E.....429 S. St. James Blvd. (14)
Kincaid, Robert S.....1000 N. Spring St. (11)
Kleindorfer, Roscoe L...819 W. Franklin St. (10)

L

Laubscher, Clarence.....1201 Laubscher Rd. (10)
Lawler, John F.....420 Cherry St. (13)
Lawrence, Joseph C.....715 First Ave. (10)
Leibundguth, Henry.....3700 Bellemeade (15)
Leich, Charles F.....124 S. E. First St. (8)
Lessure, Alfred P.....420 Cherry St. (13)
Lewis, Earl T.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Longstaff, John P.....516 S. E. Fourth St. (13)
Lynch, Harold D.....Mead Johnson & Co., 2404 Pennsylvania St. (21)

M

MacKenzie, Pierce.....126 S. E. Seventh St. (8)
McCool, Joseph H.....1 Woodmere Lane (11)
McDonald, Joseph D.....517 Sycamore St. (8)
McPherson, Thomas C.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Manner, Richard J.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Marvel, James A.....420 Cherry St. (13)
Mason, Everett E.....118 S. E. First St. (8)
Mathews, James R.....715 First Ave. (10)
Miller, LaVerne B.....714 N. Main St. (11)
Miller, Milton J.....15 W. Franklin St. (10)
Mills, Fred E.....Deaconess Hospital (10)
Mino, Robert A.....723 Mary St. (10)
Mitchell, John B.....Mead Johnson & Co., 2404 Pennsylvania St. (21)
Moulton, Lillian G.....1 N. Barker (12)
Muelchi, Adeline F.....518 Hulman Bldg. (8)
Mullican, William S., Jr.....715 First Ave. (10)
Murphy, Edward U.....901 Hulman Bldg. (8)

N

Nenneker, Henry (S)..1912 Harmony Way (12)
Newnum, Raymond L.....3700 Bellemeade (15)
Newsome, Cola K.....415 E. Mulberry (13)
Nicholson, Raymond W.....3700 Bellemeade (15)
Niedermayer, Alfred J. 960 Washington Ave. (13)
Nonte, Leo R.....715 First Ave. (10)

O

Oswald, Robert H.....126 S. E. Seventh St. (8)

P

Pastor, Julius W.....3700 Washington Ave. (15)
Pavlick, Theodore J.....908 Hulman Bldg. (8)
Pemberton, Jack J.....319 N. St. Joseph Ave. (12)
Porro, Francis W.....3700 Washington Ave. (15)
Present, Julian D.....3700 Bellemeade (15)
Price, Shirley G.....420 Cherry St. (13)
Pugh, Willis L.....715 First Ave. (10)

R

Radcliff, Forest F., Jr.....3700 Bellemeade (15)
Ratcliffe, Albert W.....P. O. Box 624
Reich, Clarence E.....1209 N. Fulton (10)
Rietman, H. Jerome
19 Chandler, off Riverside (13)
Ritchie, William D.....555 Herndon Dr. (11)
Ritz, Albert S.....3700 Bellemeade (15)
Robinson, Earle U.....615 Bellemeade (13)
Rosato, Edward J.....19 Chandler Ave. (13)
Rosenblatt, Bernard B.....709 Hulman Bldg. (8)
Royster, George M. (S)
401 Citizens Nat'l. Bank Bldg. (8)
Royster, Robert A.
401 Citizens Nat'l. Bank Bldg. (8)
Rudolph, Kenneth J.....3700 Bellemeade (15)
Rupper, Warren R...R. R. 3, Box 159, Heckel Rd.
Rusche, Henry J.....313 W. Iowa (10)
Russell, Richard H...3700 Washington Ave. (15)

S

Schimmelpfennig, Robert W.
1013 Parrett St. (13)
Schirmer, Robert H.....1118 W. Franklin St. (10)
Schneider, Charles P...2211 W. Franklin St. (12)
Schriefer, Victor V.....1120 N. Main St. (11)
Sheehan, E. Gregg.....420 Cherry St. (13)
Shively, Wyant J.....3700 Washington Ave. (15)
Siegel, Lyle P.....1152 S. Villa Dr. (14)
Sinn, Charles M.....715 First Ave. (10)
Slaughter, Howard C.....908 Hulman Bldg. (8)
Slaughter, John C., Jr.....3700 Bellemeade (15)
Slaughter, Owen L.....3700 Bellemeade (15)
Smith, Gordon L.....19 Chandler Ave. (13)
Smith, Roy M., Jr.....1307 Stringtown Rd. (11)
Snively, William D., Jr.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Sprecher, Herman C.....527 Sycamore St. (8)
Springstun, Walter R.....715 First Ave. (10)
Stallings, Hugh A.....3700 Bellemeade (15)
Steele, Paul W.....1218B Lincoln Ave. (14)
Sterne, John H.....3700 Bellemeade (15)
Stewart, L. Ray.....852 S. Alvord Blvd. (14)
Stork, Urban F. D.....420 Cherry St. (13)
Strueh, Paul E.....220 S. E. Seventh St. (13)

T

Tager, Stephen N.....3700 Bellemeade (15)
Tilden, Margaret H.....1127 Lincoln Ave. (14)
Tisserand, John B., Jr.....3700 Bellemeade (15)
Tuholski, James M.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Turner, Isabel B...Evansville State Hospital (2)
Tweedall, Daniel C.....715 First Ave. (10)

U-V

Venables, Albert J.....600 Mary St. (10)
Viehe, Robert W. (S)....618 S. Willow Rd. (14)
Vincent, William A.....420 Cherry St. (13)
Visher, John W. (S)
805 Old National Bank Bldg. (10)
VonderHaar, Thomas E.....715 First Ave. (10)

W

Walter, Paul A. F., III.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Walter, Robert F.....1514 S. Kentucky Ave. (14)
Warner, Charles L.....420 Cherry St. (13)
Waters, George E...Evansville State Hospital (2)
Watson, James L.....3809 Washington Ave. (15)
Weber, Edgar H.....123 S. E. Second St. (8)
Weiss, Henry G. (S)....1014 E. Powell Ave. (14)
Welborn, Mell B.....420 Cherry St. (13)
Westerman, Richard L.....Mead Johnson & Co.,
2404 Pennsylvania St. (21)
Wilhelmus, C. Kenneth..115 S. E. Seventh St. (8)
Wilhelmus, Gilbert M...1028 Washington Ave. (14)
Willis, Charles F.....1100 S. Bedford Ave. (13)
Willison, George W.....3700 Bellemeade (15)
Wilson, David.....1709 Southeast Blvd. (14)
Wilson, John D.....3700 Bellemeade (15)
Wilson, Ralph.....517 Mary St. (10)
Woods, William P. (S)....5050 Lincoln Ave. (15)
Woodson, Dan E.....414 S. Kelsey Ave. (14)
Woodward, Ben E.....420 Cherry St. (13)
Wynn, Justice F.....905 Hulman Bldg. (8)

X-Y-Z

Young, C. Curtis, Jr.....126 S. E. Seventh St. (8)
Zeier, Francis G.....420 Cherry St. (13)
Zimmerman, Harold.....6 S. E. Second St. (8)
Ziss, Robert C.....216 S. E. Riverside (13)
Zwickel, Ralph E.....906 Hulman Bldg. (8)

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Maxson, Roy V.....5836 Gateway Dr., Indianapolis
Poncher, John R.....605 E. Monroe St., Valparaiso
Baylor, Joseph P.
123-4 Sirrocco Dr., Minot AFB, N. Dakota
Cymbala, Bohdan.....Methodist Hospital,
Adkinson Park, Henderson, Ky.
Ehrich, William S. (S)....Manning, So. Carolina
Lyman, Frank L.....Geigy Chemical Corp.,
P. O. Box 430, Yonkers, N. Y.
Newman, Alvin E. (S)
2937 Coral Shores Dr., Ft. Lauderdale, Fla.

## VERMILLION COUNTY

**(See Parke-Vermillion)**

## VIGO COUNTY

Loving, Jury B.....New Goshen
McIntosh, Wilbert.....Riley
Jett, Clyde W.....Seelyville

**Terre Haute**

A

Allen, William H.....414 Merchants Bank Bldg.
Anderson, Walter C.....2235 Wabash Ave.
Ault, Roy J.....3050 Poplar St.

B

Bannon, William G.....500 Rose Dispensary Bldg.
Blum, Leon L.....1505 N. Seventh St.
Bopp, Henry W., Jr.....221 S. Sixth St.
Bopp, James.....Union Hospital
Boyd, H. Clark.....221 S. Sixth St.
Bristol, Henry M. S.....1218½ Wabash Ave.
Bronson, Paul J.....3050 Poplar St.
Brown, Robert R.....221 S. Sixth St.
Burkle, Robert J.....3050 Poplar St.

C

CaJacob, Melville E.....1000 S. Sixth St.
Caldwell, Milton V.....416 Tribune Bldg.
Carpenter, Donald J....507 Rose Dispensary Bldg.
Cavins, Alexander W.....221 S. Sixth St.
Chau, Andrew Y. S.....405 S. Sixth St.
Combs, Stuart R.....3050 Poplar St.
Conforti, Victor P.....221 S. Sixth St.
Congleton, George C. (S)
308 Merchants National Bank Bldg.
Conklin, James O.....310 Rose Dispensary Bldg.
Connerley, Marion L.....107 S. Seventh St.
Conway, Thomas J.....221 S. Sixth St.
Crockett, Wayne A.....500 Rose Dispensary Bldg.

D

Davis, Paul E.....1233 Maple Ave.
Dierdorf, Fred W.....Union Hospital
Drummy, William W.....221 S. Sixth St.
Dyer, George W.....2235 Wabash Ave.

E

Edwards, Henry G.....6 Rose Dispensary Bldg.
Ensey, Philip L.....Indiana State University

F

Freed, John E., Jr.....1030 S. Sixth St.

G

Gerrish, Donald A.....5206 Clinton Road
Goodman, Hubert T...410 Rose Dispensary Bldg.
Gossom, Donn R.....825 N. Third St.

H

Harkness, Robert G...301 Rose Dispensary Bldg.
Haslem, Ezra R.....401 Rose Dispensary Bldg.
Haslem, John R.....221 S. Sixth St.
Hogan, Thomas W.....627 Cherry St.
Hoover, Dewey A.....1218½ Wabash Ave.
Humphrey, Paul E.....1235 Ohio Blvd.
Hunt, Edgar J.....R. R. 1

J

Johnson, Edward M.....221 S. Sixth St.
Johnson, Paul D., Jr.....822 N. 15th St.
Justin, Renate G.....901 S. 25th St.

K

Kabel, Robert N.....3050 Poplar St.
Krieble, William W.....221 S. Sixth St.
Kunkler, Arnold W.....1700 N. Seventh St.
Kunkler, Joseph (S).....14 S. Fifth St.
Kunkler, William C. (S)
212 Merchants Nat'l. Bank Bldg.

L

LaBier, Clarence R., Jr.....325 Ohio St.
Lancet, Robert O.....2101 Wabash Ave.
Lee, James.....465 S. 25th St.
Lo, Loretta S. Y.....349 S. 18th St.
Loewenstein, Werner L.....1537 S. Seventh St.
Luckett, Coen L. (S).....211 Fairbanks Bldg.
Lyons, L. Mason.....59 S. 18th St.

M

McAleese, George B.....1030 S. Sixth St.
McBride, Noel S..407 Merchants Nat'l. Bank Bldg.
McCrea, Fred R.....221 S. Sixth St.
McEwen, James W.....670 Cherry St.
McLaughlin, Gordon C.....1644 S. 25th St.
Mahoney, Charles L.....221 S. Sixth St.
Malone, Leander A.....416 Tribune Bldg.
Mankin, William J.....402 Tribune Bldg.
Mason, Lester M..314 Merchants Nat'l. Bank Bldg.
Mattox, Don M.....1700 N. Seventh St.
Meissel, Robert L.....920 N. 19th St.
Miklozek, John E.....1461 S. Seventh St.
Milleson, Ann L. M.....826 S. Center St.
Mitchell, John R.....221 S. Sixth St.
Musselman, Glen G.....1021 S. Sixth St.

N-O

Nay, Ernest O. (S).....221 S. Sixth St.
Neudorff, Louis G.....221 S. Sixth St.
Oliphant, Robert W.....1603 S. Seventh St.

P

Paulsen, Suzanne M.....1505 N. Seventh St.
Pearce, Roy V.....1440 S. 25th St.
Pu, Pin H.....1021 S. Sixth St.

R

Reed, Robert C.....Union Hospital
Reynolds, Richard J.....2250 Wabash Ave.
Richart, James V.....414 Rose Dispensary Bldg.
Riggs, Floyd C.....2216 Wabash Ave.
Rogers, R. Shirrell.....26 N. Sixth St.,
West Terre Haute
Rourke, Robert F.....1724 N. Seventh St.
Rubin, Milton M.....221 S. 19th St.

S

Sayers, Frank E. (S).....436 Bluebird Dr.
Scherb, Burton E.....104 N. Seventh St.
Schott, Edward J. (S).....653 Oak St.
Schumaker, Robert A.....3050 Poplar St.
Scully, William E.....221 S. Sixth St.
Shanklin, Vernon A. (S).....672½ Wabash Ave.
Showalter, John R.....1233 Maple Ave.
Siebenmorgen, Paul.....1200 S. Eighth St.
Silverman, Norman M.....1634 S. Seventh St.
Speas, Robert C.....402 Tribune Bldg.
Stewart, Walter E. (S).....402 Tribune Bldg.
Stoelting, J. Lewis.....1724 N. Seventh St.
Strecker, William L.....2006 Wabash Ave.
Strong, Daniel S. (S).....2618 Lafayette Ave.
Sullivan, John M.....1712 Franklin St.

T-U-V

Topping, Malachi C.....3050 Poplar St.
Vance, William C.....Indiana State University
Veach, William L.....1235 Ohio St.
Voges, Edward C.....702 College Ave.

W

Walden, Heinz J.....213 Gilbert Ave.
Weber, Joseph G. S.....723 Wabash Ave.
Weinbaum, Jack G.....1505 N. Seventh St.
Wheeler, Byron C.....3050 Poplar St.
White, James V.....502 Tribune Bldg.
Wilson, Fred L.....1501 S. Third St.
Wohlfeld, Gerald M.....203 Arcadia Dr.

X-Y-Z

Zwerner, Paul F.....12 Points State Bank Bldg.

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Gillotte, Joseph P....5113 Homer Ave., Tampa, Fla.
Meyn, Werner P.....2375 Lariat Dr., Eugene, Ore.

## WABASH COUNTY

Poehler, Fred C.....La Fontaine
Walker, James L. (S).....La Fontaine

### North Manchester

Balsbaugh, George K.....107 W. Seventh St.
Bunker, Ladoska Z.....201 N. Mill St.
Cook, Charles E.....114 W. Main St.
Eiler, Paul A.....1104 N. Wayne St.
Seward, George W.....111 E. Main St.
Smith, Lloyd H.....1104 N. Wayne St.

### Wabash

Boaz, William D.....106 Parkway
Dannacher, William D.....400 Ash St.
Dragoo, John R.....Washington & Ash St.
Dunham, Henry H.....Wabash Professional Bldg.
Elward, Carl J.....R. R. #4
Hanneken, Vincent J.....400 Ash St.
LaSalle, Richard M.....645 N. Spring St.
LaSalle, Robert M., Jr.....645 N. Spring St.
LaSalle, Robert M., Sr.....645 N. Spring St.
Mills, John F.....24 E. Main St.
Pearson, William E.....290 N. Wabash
Rauh, Robert A.....884 N Miami St.
Steffen, Julius T.....443 N. Wabash
Stoops, Jean T.....400 Ash St.
Whisler, Frederick M. (S).....10 W. Hill
Zydlo, Stanley M.....Wabash Professional Bldg.

---

Kidd, James G. (S).....720 West Racine St.,
Apt. B, Jefferson, Wis.

## WARREN COUNTY

**(See Fountain-Warren)**

## WARRICK COUNTY

**Boonville**

Hoover, Peter B.....223 W. Locust St.
Stover, Wendell C.....125½ S. Second St.
Terry, Robert H.....117 S. Second St.
Wilson, Paul E. (S).....126 N. Third St.

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Dimmett, James D.....Chandler
Colvin, Robert C.....Newburgh
Wilhelmus, Charles M. (S).....Newburgh

## WASHINGTON COUNTY

Tower, Thomas K.....Campbellsburg
Carty, Charles B.....Pekin

**Salem**

Apple, Eddie R.....501 W. Market St.
Coleman, Henry G.....Mitchell Bldg.
Episcopo, Arsenius R.....401 W. Mulberry St.
Fultz, Roy L.....304 E. Market St.
Huckleberry, Irvin E.....502 W. Mulberry St.

## WAYNE-UNION COUNTIES

Hill, Paul G.....Cambridge City
Kenyon, C. Emil.....Cambridge City
Barton, Willoughby M.....Centerville
Hutchison, Donald R.....Fountain City

**Liberty**

Clarkson, Clarence G.....304 E. Union St.
Lewis, James F.....28 E. Union St.
McWilliams, William B.....207 N. Market St.

**Richmond**

Adney, Frank B., Jr.....1015 S. A St.
Ake, Loren.....213 Medical Arts Bldg.
Allen, Robert T.....34 S. Seventh St.
Anderson, Robert C.....Richmond State Hosp.
Ballenger, William E.....309 Medical Arts Bldg.
Blossom, Paul W.....825 S. A St.
Brooks, G. Tanner.....29 S. 12th St.
Brown, Richard J.....84 S. 14th St.
Buche, Frederick P. (S).....106 S. Seventh St.
Coble, Frank H.....51 S. Eighth St.
Cox, Leon T.....1210 E. Main St.
Daggy, James R.....35 S. Eighth St.
Dingle, Paul E.....216 Medical Arts Bldg.
Dreyer, Ralph W.....2 S. W. 17th St.
Ebbinghouse, Tom.....98 W. Main St.
Gibson, Alois E.....1250 Chester Blvd.
Guthrie, James R.....1010 S. A St.
Hagie, Franklin E.....1110 S. A St.
Hance, Darwood B.....Reid Memorial Hospital
Harmon, Carl J.....407 Medical Arts Bldg.
Hill, Gladys Marie.....407 Medical Arts Bldg.
Hunt, Gayle J.....425 S. 19th St.
Johnson, George M.....1250 Chester Blvd.
Kendall, William R.....126 S. 24th St.
Kime, Charles E.....1201 S. A St.
Klepfer, Jefferson F....Richmond State Hospital
Kreitl, Dorothy R.....Richmond State Hospital
Lee, Glen Ward.....139 Medical Arts Bldg.
Ling, John F.....1250 Chester Blvd.
Logan, James Z.....84 S. 14th St.
Loomis, Charles H.....1203 S. A St.
McIlroy, Richard J.....Richmond State Hospital
Mader, John H.....2000 E. Main St.
Mahrt, Delmar H.....Reid Memorial Hospital
Malcolm, Russell L.....127 Medical Arts Bldg.
Meredith, Elwood J.....203 Medical Arts Bldg.
Miller, Harold L. .....1250 Chester Blvd.
Millis, Arthur B.....1250 Chester Blvd.
Park, Byron J.....1250 Chester Blvd.
Pentecost, Paul S.....1300 Chester Blvd.
Plasterer, Edward D.....212 S. 16th St.
Porter, George S.....1010 S. A St.
Ramsdell, Glen A.....1015 S. A Street
Runge, Paul W.....1426 E. Main St.
Sage, Charles V., Jr.....48 S. 11th St.
Schmitt, Robert W.....25 Circle Drive
Sherer, Kenneth E.....1250 Chester Blvd.
Shields, Tom S.....47 S. 11th St.
Snyder, Morris C.....130 Medical Arts Bldg.
Stepleton, John D.....Reid Memorial Hospital
Stilwell, William R.....2607 South C Place
Sweet, Howard E.....35 E. Eighth St.
Wanninger, Horace (S).....2 N. Eighth St.
Warrick, Francis B.....1426 E. Main St.
Weinstein, Edwin B.....204 Colonial Bldg.
Weitemier, Raymond A.....2000 E. Main St.
Wertenberger, Morris D...Reid Memorial Hospital
Wiland, Olin K.....Reid Memorial Hospital
Wynegar, David E.....Richmond State Hospital
Zore, Joseph J.....1308 North A Street

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Shepard, Fred F.....College Corner, Ohio

## WELLS COUNTY

**Bluffton**

Bixler, James A.....303 S. Main St.
Boonstra, Charles E.....303 S. Main St.
Bradley, Louis F.....303 S. Main St.
Buckner, Joy F.....116 E. Walnut St.
Caylor, Charles H.....303 S. Main St.
Caylor, Harold D.....303 S. Main St.
Caylor, Truman E.....303 S. Main St.
Collins, Jack T.....303 S. Main St.
Cook, Robert G.....303 S. Main St.
Dorrance, Thomas O.....303 S. Main St.
Eisaman, Jack L.....303 S. Main St.
Gitlin, Max M.....121 E. Market St.
Gitlin, William A.....121 E. Market St.
Hamilton, Orville G. (S).....227 S. Main St.
Huffman, Galen C.....303 S. Main St.
Jackson, Charles E.....303 S. Main St.
Kephart, S. Bruce.....303 S. Main St.
Lehman, Emery W.....904 S. Bennett St.
Matzen, Richard N.....303 S. Main St.
Mayock, Peter P.....303 S. Main St.
Mead, Clarence H. (S).....227 S. Main St.
Meier, Donald W.....303 S. Main St.
Panos, Constantine G.....227 S. Main St.
Phillips, John F.....303 S. Main St.
Pietz, David G.....303 S. Main St.
Rusher, Merrill W.....303 S. Main St.
Segmiller, William C., Jr.....303 S. Main St.
Sorg, David A.....303 S. Main St.
Steckbeck, Robert L.....303 S. Main St.
Stevens, Adam C.....303 S. Main St.
Strehler, Don A.....303 S. Main St.
Symon, William E.....303 S. Main St.
Talbert, Pierre C.....303 S. Main St.
Yoder, Richard P.....303 S. Main St.

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Gingerick, Charles M.....Liberty Center
Hardin, Wayne E.....Ossian

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Rudy, Donald B.
P. O. Mnene, via Belingwe, Rhodesia, S. Africa

## WHITE COUNTY

Galbreth, Jesse P. (S).....Burnettsville
McClure, Stanley E.....Monon

**Monticello**

Beck, David C.....135 S. Illinois St.
Dickerson, W. Martin.....1114 O'Connor Blvd.
Hibner, Nolan A.....110 S. Main St.
Jehanyar, M. Ali.....116 N. Illinois St.
Morris, Warren V.....115 W. Marion St.

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Baynes, Frank L.....Wolcott
Forbes, Violet Crabbe.....Wolcott

## WHITLEY COUNTY

Hershey, Ernest A. (S).....Churubusco
Minick, Linus J.....Churubusco

**Columbia City**

Hamilton, Thomas.....115 S. Main St.
Heritier, C. Jules.....116 S. Chauncey
Langohr, John L.....215 E. Van Buren St.
Lehmberg, Otto F. C.....118 E. Van Buren St.
Niccum, Warren L.....215 E. Van Buren St.
Nolt, Ernest V. (S).....103 N. Line
Reid, Donald B.....2 Hallmark Square
Roth, James R.....323 N. Chauncey
Thompson, Frank M.....510 N. Main St.
Vogel, John L.....215 E. Van Buren St.
Wait, Jerome H.....115 S. Main St.
Wilson, John.....122 N. Main St.

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Stalter, Gaylord W.....North Webster
Mishler, Joe B.....P. O. Box 276, Pierceton
Yoder, Dewey D.....R. R. #1, Pierceton
Huffman, Verlin P...701 State St., South Whitley

# WOMAN'S AUXILIARY
## to the
# INDIANA STATE MEDICAL ASSOCIATION

## OFFICERS: 1965-66

| | | | |
|---|---|---|---|
| PRESIDENT | Mrs. H. Carter Dunstone | 2525 Paulding Rd. | Fort Wayne |
| PRESIDENT-ELECT | Mrs. Alfred B. Scales | Holland Rd. | Huntingburg |
| IMMEDIATE PAST PRESIDENT | Mrs. Jack E. Shields | 721 W. Spring St. | Brownstown |
| FIRST VICE-PRESIDENT | Mrs. S. Bruce Kephart | P.O. Box 12 | Bluffton |
| NORTHERN VICE-PRESIDENT | Mrs. R. J. Morrical | 415 Highland St. | Logansport |
| CENTRAL VICE-PRESIDENT | Mrs. John W. Deever | 6801 S. East St. | Indianapolis |
| SOUTHERN VICE-PRESIDENT | Mrs. Paul A. Clouse | 5801 Newburgh Rd. | Evansville |
| RECORDING SECRETARY | Mrs. William A. Matthews | 1122 N. Bolton | Indianapolis |
| TREASURER | Mrs. Otis R. Bowen | 304 N. Center St. | Bremen |
| CORRESPONDING SECRETARY | Mrs. William A. Kleifgen | 4602 Tacoma Ave. | Fort Wayne |
| FINANCE SECRETARY | Mrs. M. O. Scamahorn | | Pittsboro |
| HISTORIAN | Mrs. Edward L. Rigley | 1704 Ridgedale Rd. | South Bend |
| PARLIAMENTARIAN | Mrs. Frank Gastineau | 4444 Kessler Blvd., E. Dr. | Indianapolis |

## COMMITTEE CHAIRMEN

| | | | |
|---|---|---|---|
| AMA-ERF (CHAIRMAN) | Mrs. John W. Rousseau | 3018 Devon | Fort Wayne |
| AMA-ERF (TREASURER) | Mrs. Carl W. Goebel | 4102 S. Harrison St. | Fort Wayne |
| BYLAWS | Mrs. John M. Sullivan | 2242 College Ave. | Terre Haute |
| COMMUNITY SERVICE | Mrs. Robert M. Seibel | Box 127 | Nashville |
| DISASTER PREPAREDNESS | Mrs. Albert L. Marshall | 7802 Allisonville Rd. | Indianapolis |
| EDITORIAL | Mrs. Frank Green | 516 N. Morgan St. | Rushville |
| HEALTH CAREERS | Mrs. Milton V. Caldwell | R.R. 7, Box 449 | Terre Haute |
| LEGISLATION | Mrs. Dwight W. Schuster | 4503 Washington Blvd. | Indianapolis |
| INTERNATIONAL HEALTH ACTIVITIES | Mrs. Joseph Clark | R.R. 9 | Huntington |
| MEDICAL CARE INSURANCE | Mrs. Paul Sparks | 601 W. Will St. | Winchester |
| MEMBERSHIP | Mrs. Bruce Kephart | P.O. Box 12 | Bluffton |
| MENTAL HEALTH | Mrs. Richard G. Horswell | 1629 Jackson Blvd. | Elkhart |
| ORGANIZATION | Mrs. Alfred B. Scales | Holland Rd. | Huntingburg |
| PROGRAM | Mrs. Alan Fischer | 2515 Knollwood Dr. | Indianapolis |
| PUBLICITY | Dr. Margaret Ball | 4112 S. Harrison St. | Fort Wayne |
| RURAL HEALTH | Mrs. Francis Gootee | R.R. 1 | Jasper |
| SAFETY | Mrs. Stephen D. Smith | 308 N. Washington St. | Knightstown |
| LIAISON OFFICER to the Indiana Chapter of W.A.S.A.M.A. | Mrs. Herbert L. Egbert | 419 W. 63rd St. | Indianapolis |
| 1965 ISMA CONVENTION CHAIRMAN | Mrs. Francis L. Land | 4129 S. Harrison St. | Fort Wayne |
| 1966 CONVENTION CHAIRMEN, HOUSE OF DELEGATES | Mrs. Donald S. Painter | 110 Southridge Rd. | Fort Wayne |
| | Mrs. Gerald H. Somers | 1253 W. Rudisill Blvd. | Fort Wayne |

## MEMBERSHIP ROSTER—BY COUNTIES

### ADAMS COUNTY

**Berne**

Beaver, Mrs. Norman E.....866 Columbia Dr.
Boze, Mrs. Robert L.....255 Dearborn St.

**Decatur**

Burk, Mrs. James M.....221 S. 3rd St.
Carroll, Mrs. John C.....R. R. 5
Doan, Mrs. John.....522 Jefferson
Freeby, Mrs. C. William.....R. R. 1
Girod, Mrs. Arthur A.....R. R. 6
Parrish, Mrs. Richard K.....242 S. 2nd St.
Rich, Mrs. Norval S.....R. R. 4
Zwick, Mrs. Harold F.....104 E. Rugg

### ALLEN COUNTY

**Bluffton**

Brickley, Mrs. Harry D.....227 S. Main St.
Buckner, Mrs. Winifred.....116 E. Walnut
Hamilton, Mrs. O. G.....203 E. Central Dr.

**Fort Wayne**

A

Adams, Mrs. E. Wade....1902 Forest Park Blvd.
Ahlbrand, Mrs. Roland C.....1242 Northlawn
Aiken, Mrs. Arthur F.....8331 Waterswolde Lane
Aiken, Mrs. Nevin E.....5540 Leo Rd.
Anderson, Mrs. Garland.....1241 Bethany Lane
Andrew, Mrs. Jerald.....401 W. Sherwood Terrace

Arata, Mrs. James.....126 Timber Lane
Arata, Mrs. Justin E.....224 Ludwig Rd.
Ashman, Mrs. William C.....1018 Kinnaird
Aust, Mrs. Charles H.....7137 Roseann Parkway

B

Ball, Mrs. John R.....4112 S. Harrison
Baltes, Mrs. Joseph H.....1309 Sunset Dr.
Barch, Mrs. John W.....4921 Desoto Drive
Bash, Mrs. Wallace E.....1201 Korte Lane
Beams, Mrs. Ralph.....3710 Wawonaissa
Beierlein, Mrs. Karl M.....2716 Butler Road
Bergendahl, Mrs. Emil.....1202 Illsley
Berghoff, Mrs. J. R.....3736 Plymouth
Berghoff, Mrs. Raymond.....4124 Cadena
Beutler, Mrs. Theodore....3505 S. Washington Rd.
Bierman, Mrs. Gilbert.....1015 College Ave.
Billingsley, Mrs. John.....4720 Crestwood
Blichert, Mrs. Peter A.....449 W. Sherwood
Bolman, Mrs. R. Morton.....5405 S. Wayne
Borders, Mrs. Theodore R.....1802 Nevada St.
Bossard, Mrs. John W.....1611 Alabama
Bowers, Mrs. Geo. W.....2120 Kensington
Brandt, Mrs. William.....3535 Kirkland
Braunlin, Mrs. Robert J.....3423 Kirkland Lane
Bridges, Mrs. W. Lloyd.....207 Southridge Rd.
Bromley, Mrs. Luman W...410 W. Sherwood Ter.
Brosius, Mrs. Robert H.....3302 Garland
Brown, Mrs. Frederic W.....1813 Woodmoor
Brown, Mrs. Garland R.....5522 W. Hamilton Dr.
Brucker, Mrs. Perry A.....2933 Kingsley
Brueggeman, Mrs. Henry O...1202 W. Washington
Bryan, Mrs. Franklin A.....3006 Devon Dr.
Buckner, Mrs. Doster.....Bass Rd., R. R. 5
Buckner, Mrs. George D.....4327 Hampshire Dr.
Burkhart, Mrs. Charles A.....7621 Pinedale Dr.

C

Carlo, Mrs. Ernest.....5205 Indiana
Cartwright, Mrs. E. L.....3718 Hiawatha Blvd.
Chambers, Mrs. Alan.....4135 S. Harrison
Chase, Mrs. James A.....4120 N. Washington Rd.
Clark, Mrs. Wm. R.....4002 S. Harrison
Cochran, Mrs. Harry A., Jr..420 W. Sherwood Ter.
Connelly, Mrs. Jerry.....4615 Willard Dr.
Connelly, Mrs. Richard.....3016 Kingsley Dr.
Cooney, Mrs. Charles J..2620 Covington Club Court
Cottrell, Mrs. Robert F.....5125 Worthman Ct.
Craig, Mrs. Richard.....5435 Woodhurst Blvd.
Culp, Mrs. John E.....2505 Paulding Rd.

D

Datzman, Mrs. Richard.....5402 Bluffton Rd.
Davidoff, Mrs. Manuel A.....5408 Bluffton Rd.
Dunstone, Mrs. H. Carter....2525 Paulding Road

E

Eberly, Mrs. Karl C.....1240 W. Rudisill
Emenhiser, Mrs. John L.....1407 Pinehurst Dr.
Engleman, Mrs. Reinhold.....3629 Chancellor Dr.
Epps, Mrs. James.....2120 Hobson Rd., Apt. 111A

F

Farquhar, Mrs. John S.....5206 Indiana
Ferguson, Mrs. Arthur N.....328 W. Sherwood
Flaherty, Mrs. Robert....1835 Forest Park Blvd.
Foy, Mrs. Thomas.....2618 Glenwood Ave.
Franke, Mrs. Gordon.....6216 Midwood Dr.
Frankhouser, Mrs. Chas. M...7245 Winchester Rd.
Fullam, Mrs. Richard.....4159 Woodstock

G

Garton, Mrs. Harry W.....R. R. 6, Hamilton Rd.
Gastineau, Mrs. David C.....8203 Westridge Rd.
Gentile, Mrs. J. Paul.....6821 Woodcrest Dr.
Gerding, Mrs. William J...1721 Forest Park Blvd.
Giffin, Mrs. Charles.....3222 Chancellor
Glassley, Mrs. Stephen.....6950 Stellhorn Rd.
Glock, Mrs. Maurice E.....1502 Hawthorne Rd.
Glock, Mrs. Wayne R.....Tonkel Road R.R. 2
Goebel, Mrs. Carl W.....4102 S. Harrison
Graham, Mrs. George M.....1126 W. Rudisill
Graham, Mrs. James C.....2835 Devon Dr.
Green, Mrs. Robert F.....4429 Hamilton Rd.
Greenlee, Mrs. Robert L.....3344 Sanibel Dr.
Griest, Mrs. Walter D.....4809 Arlington
Griffith, Mrs. Harold R...1913 Forest Park Blvd.

H

Hackett, Mrs. Walter G.....5220 Crandon Lane
Haffner, Mrs. Herman G.....3606 Mulberry Rd.
Haley, Mrs. Alvin J.....3720 Stellhorn Rd.
Hall, Mrs. William R.....4521 Highwood
Haller, Mrs. Richard C.....2525 Otsego
Hamilton, Mrs. Emory D.....2405 Florida Dr.
Hamilton, Mrs. George.....4531 Highwood Dr.
Hasewinkle, Mrs. August M...3544 Kirkland Lane
Hastings, Mrs. Warren C.....1822 Kensington Rd.
Hattendorf, Mrs. A. Paul.....4041 Old Mill Rd.
Havens, Mrs. Russell E.....3721 Inwood
Hershberger, Mrs. Philip G...5525 Covington Rd.
Hickman, Mrs. Donald M.....1815 Kensington Rd.
Hillery, Mrs. Robert.....3513 Kirkland Lane
Hipskind, Mrs. Richard E.....1416 Woodmoor
Hoffman, Mrs. Arthur F.....3619 Harris Rd.
Holsinger, Mrs. Robert E.....4617 Indiana
Hoover, Mrs. Joseph.....722 W. Creighton
Howe, Mrs. Fordyce L.....2540 Springfield
Humphreys, Mrs. John L...3701 S. Washington Rd.

I & J

Irmscher, Mrs. Geo. W.....2024 Florida Dr.
Isenogle, Mrs. Kenneth.....4201 Brooklawn Dr.
Jackson, Mrs. John F.....4922 Indiana
Jontz, Mrs. Joseph.....514 Shady Hurst Dr.
Jontz, Mrs. Richard L.....3705 Marigold Dr.
Juergens, Mrs. Richard.....6825 Ludwig Circle

K

Karol, Mrs. Herbert J.....1725 Ardmore
Kaufman, Mrs. Julian R.....5405 Old Mill Rd.
Keck, Mrs. Carleton A.....4633 Crestwood
Kent, Mrs. Richard N.....2717 East Dr.
Keyes, Mrs. Robert C.....1226 Illsley
Kidder, Mrs. Orva T.....Lima Rd.
Kilgore, Mrs. Byron.....2804 Trent Dr.
Kimbrough, Mrs. Robert.....4601 Beaver Ave.
Kleifgen, Mrs. Wm. A.....4602 Tacoma
Kleopfer, Mrs. Ronald G.....7445 Leo Rd.
Klooze, Mrs. Kenneth W.....723 W. Packard
Knight, Mrs. Lewis W.....3502 Glencairn Dr.
Krueger, Mrs. John.....4418 Bradwood Terrace
Kruse, Mrs. Walter E.....4006 Spanish Trail

L

Ladig, Mrs. Donald S.....2720 Fairfield
Laker, Mrs. Gene C.....4635 Old Mill Rd.
Laker, Mrs. Richard J.....1301 Sheridan Ct.
Lampe, Mrs. Elfred H.....4255 Hartman Rd.
Land, Mrs. Francis L.....4129 S. Harrison Blvd.
Laycock, Mrs. Richard.....5019 Stellhorn Rd.
Lee, Mrs. John W.....3336 Rockwood Dr.
Leming, Mrs. Ben L.....314 W. Concord Lane
Lenk, Mrs. George G.....5507 E. State St.
Lloyd, Mrs. Robert P.....4111 Victoria Dr.
Logan, Mrs. Richard S.....5225 Vance
Lohman, Mrs. Robert M.....1320 Westover Rd.
Lorman, Mrs. James G.....4926 Midlothian
Loudermilk, Mrs. Jack L.....3032 Glencairn Dr.
Lyon, Mrs. William C.....5005 Stratford Rd.

M

McArdle, Mrs. Edward G...1133 W. Rudisill Blvd.
McBride, Mrs. W. O.....2121 Engle Rd.
McCallister, Mrs. John W.....4215 Drury Lane
McCoy, Mrs. Roy R.....4101 S. Harrison
McDowell, Mrs. George A...2322 Forest Park Blvd.
McEachern, Mrs. Cecil.....4242 Old Mill Rd.

McKeeman, Mrs. Donald H.....1615 Ardmore
Mann, Mrs. R. E.....4035 Cadena Lane
Manning, Mrs. George.....4115 Indiana Ave.
Marsh, Mrs. M. Frederick.....3721 Central Dr.
Marshall, Mrs. Caesar L.....1215 McCulloch
Mastrangelo, Mrs. Michael J...2718 Priscilla Lane
Mensch, Mrs. James R.....2120 Forest Park Blvd.
Mercer, Mrs. S. R.....3235 N. Washington Rd.
Meyer, Mrs. Theo. O.....3728 Kirkwood
Michaelis, Mrs. Stephen C.....1255 Korte Lane
Miller, Mrs. Carl G.....457 Oakdale Dr.
Miller, Mrs. Don E.....3329 Argyle Dr.
Miller, Mrs. Edward D.....2615 East Drive
Miller, Mrs. H. Paul.....6408 S. Calhoun
Miller, Mrs. Mahlon F.....1115 Illsley
Miller, Mrs. Orval J.....1810 Kensington
Miller, Mrs. Richard.....5125 Old Mill Road
Miller, Mrs. Wm. J.....2620 Capitol
Moats, Mrs. Carl F.....3210 N. Washington Rd.
Moeller, Mrs. Victor C.....4723 St. Joe Center Rd.
Moravec, Mrs. Arthur.....4711 Old Mill Rd.
Morey, Mrs. Edwin.....709 Kinnaird
Morgan, Mrs. Milton M.....8214 Park Ridge Dr.
Mortenson, Mrs. Leland J...1310 W. Foster Pkwy.
Mueller, Mrs. Lawrence W. 3423 S. Washington Rd.
Murdock, Mrs. Harvey L.....1212 Kensington

N-O

Nill, Mrs. John H.....5316 South Wayne
Nolan, Mrs. Gerald R.....2631 Covington Club Ct.
O'Brian, Mrs. John F.....1215 N. Anthony Blvd.
O'Rourke, Mrs. Carroll.....9211 Covington Road

P

Painter, Mrs. Donald S....R. R. 1, Southridge Rd.
Parker, Mrs. C. B.....2215 Paulding Rd.
Parrot, Mrs. Donald J.....4926 Chaucer
Patterson, Mrs. Jack W.....8914 Maravilla Dr.
Perrin, Mrs. Kermit F.....2828 Lake Ave.
Pickett, Mrs. Merle E.....4509 Trierwood
Popp, Mrs. Milton F.....3148 Parnell Ave.
Powell, Mrs. M. Jack.....7412 Ridge Knoll Rd.
Priddy, Mrs. Marvin.....3902 Bonita Place

R

Rank, Mrs. William B.....3737 S. Washington Rd.
Reed, Mrs. John D.....3940 Dalewood Dr.
Rhamy, Mrs. Bonnelle W.....4312 Beaver
Richards, Mrs. Alan D.....3730 Meda Pass
Rissing, Mrs. Walter J.....3200 Irvington
Roser, Mrs. Arthur J.....5576 Covington Rd.
Rossiter, Mrs. Dudley L.....724 Oakdale Dr.
Rothberg, Mrs. Maurice.....4319 Hartman Rd.
Rousseau, Mrs. John W.....3018 Devon Dr.

S

Sahlmann, Mrs. Hans.....2402 Woodward
Salon, Mrs. Harry W.....4017 Hiawatha Blvd.
Salon, Mrs. Joel.....4935 Old Mill Road
Salon, Mrs. Nathan L.....7939 Scottwood Court
Sarver, Mrs. Francis E.....4629 Tacoma
Savage, Mrs. Arthur R.....R. R. 1, Southridge Rd.
Schlademan, Mrs. Karl R.....5231 Old Mill Rd.
Schleinkofer, Mrs. Robert.....705 Caribe Blvd.
Schloss, Mrs. Robert....414 W. Sherwood Terrace
Schmidt, Mrs. Eugene E.....1119 Maxine Dr.
Schmoll, Mrs. Robert J.....5214 Woodhurst
Schneider, Mrs. Louis A...1351 W. Sherwood Tr.
Schoen, Mrs. Fred.....5128 S. Wayne
Schoenhals, Mrs. Charles E.....2818 Inwood
Schubert, Mrs. Jerome C...4725 Wellington Drive
Scoins, Mrs. W. H.....2121 Engle Rd., Apt. 3B
Scudder, Mrs. James.....1619 Forest Park Blvd.
Shaw, Mrs. James E.....3932 Rosewood Drive
Shinabery, Mrs. Lawerence.....1850 Broadway
Shugart, Mrs. Robert R...4206 N. Washington Rd.
Singer, Mrs. Elmer C.....3121 E. Maple Grove
Sirlin, Mrs. E. M.....2615 Trier Rd.
Smith, Mrs. G. A.....2313 Florida
Smith, Mrs. Philip L.....5416 South Wayne
Smith, Mrs. Roger.....8828 Maravilla Dr.
Snyderman, Mrs. Sanford C...3222 N. Wash. Rd.
Somers, Mrs. G. H.....1253 W. Rudisill
Spencer, Mrs. C. Herbert....2106 Paulding Road
Stanley, Mrs. Robert G.....2807 Club Terrace Rd.
Stauffer, Mrs. Richard C.....3924 Spanish Trail
Steigmeyer, Mrs. David J.....6809 Woodcrest
Stellner, Mrs. Howard A.....3323 Butler Court
Stier, Mrs. Paul.....R. R. 6, 13120 Ravine Trail
Stucky, Mrs. Jerry L.....4167 Woodstock Ave.
Sullivan, Mrs. Robert E.....4145 Woodstock
Swinton, Mrs. Stanley.....1927 Hazelwood, Apt. D

T

Tennant, Mrs. David L.....3908 Spanish Trail
Terrill, Mrs. Richard.....4727 Old Mill Rd.
Thornton, Mrs. Walter E.....601 Oakdale Dr.
Tomusk, Mrs. August N.....2315 Springfield
Towles, Mrs. Jeff H.....4808 S. Anthony
Trier, Mrs. Herbert P.....3212 River Forest Dr.

U-V

Ungemach, Mrs. Willo F.....3929 Wenonah
Vogel, Mrs. Lloyd A.....5626 Dartmouth Dr.

W

Wade, Mrs. Reynolds W., Jr...4105 Dalewood Dr.
Walker, Mrs. Floyd.....1202 Forest Ave.
Wallace, Mrs. Collins.....4153 Woodstock
Warfield, Mrs. Chester H.....3924 Harris Rd.
Weber, Mrs. John R.....5313 S. Wayne
Wick, Mrs. Alfred A.....2320 Springfield Ave.
Wilkins, Mrs. Robert W.....914 Prange Dr.
Wilson, Mrs. Leslie.....4864 Reed Rd.
Wilson, Mrs. Roland B.....4100 Abbott
Wright, Mrs. William C.....1834 Pemberton Dr.
Wyatt, Mrs. James L., Jr.....2934 Grandview

Z

Zehr, Mrs. Noah.....301 W. Creighton
Zweig, Mrs. Elmer S.....2015 Pemberton

**New Haven**

Dahling, Mrs. C. Wallace..Carefree Farms, R. R. 2
Dahling, Mrs. Fred W.....1229 Rose Ave.
Emenhiser, Mrs. Don C.....1040 Lincoln Highway
Hoetzer, Mrs. Eldore M.....Doyle Rd.
Sidell, Mrs. James.....1228 Powers
Stumpf, Mrs. Edwin E.....R. R. 2, Werling Rd.

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Harvey, Mrs. Harry C...Methodist Home, Franklin
Emme, Mrs. Richard W.....R. R. 2, Grabill
Mackel, Mrs. Frederick.....R. R. 1, Huntertown
Harless, Mrs. O. Fred.....Monroeville

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Schlegel, Mrs. Edward
2009 Frieze Ave., Ann Arbor, Mich.

## BARTHOLOMEW-BROWN COUNTIES

**Columbus**

Able, Mrs. Walter.....2630 19th St.
Adler, Mrs. David L.....4224 N. Riverside Dr.
Andrews, Mrs. Fred B.....2813 DeSoto Way
Beggs, Mrs. Lowell F.....2733 Riverside Dr.
Daugherty, Mrs. Forest.....2813 31st St.
Davis, Mrs. Marvin R.....2300 N. Washington St.
Dugan, Mrs. Thomas.....2651 18th St.
Echsner, Mrs. Herman J.....300 Tipton Lane
Fisher, Mrs. Walter S.....906 Franklin St.
Fuller, Mrs. Robert.....1602 Crescent Dr.
Gammell, Mrs. Lindley L.....602 22nd St.
Grangier, Mrs. Bernard A.....3335 Grove Pkwy.
Hart, Mrs. Robert B.....1203 16th St.
Hauersperger, Mrs. Alfred D.....4164 River Rd.
Hawes, Mrs. Marvin E.....2975 Franklin Dr.
Henry, Mrs. Alvin L.....1926 Lafayette Avenue

Jacobs, Mrs. E. Robert.....2335 Riverside Dr.
Knotts, Mrs. Halleck S.....2740 Washington St.
Krueger, Mrs. Robert B.....811 27th St.
Macy, Mrs. George W.....2623 Riverside Dr.
Marr, Mrs. Griffith.....Marr Rd., R. R. 1
McCullough, Mrs. Henry G.
Old Indianapolis Rd., R. R. 4
Mohler, Mrs. Floyd W.....308 Sunset Dr.
Norton, Mrs. Harold J.....909 Pearl St.
O'Bryan, Mrs. Richard B...3306 Grove Parkway
Overmire, Mrs. Joseph E.....R. R. 2
Overshiner, Mrs. Lyman.....1715 Franklin St.
Ranck, Mrs. Benjamin A.....3370 Grove Parkway
Rau, Mrs. Charles A.....1312 Audubon Dr.
Reid, Mrs. Robert M.....2712 Lafayette Ave.
Richmond, Mrs. Harold W.....1725 Washington
Ryan, Mrs. Wm. J.....3224 Grove Parkway
Schmitt, Mrs. Richard K.....2639 Riverside Dr.
Sigmund, Mrs. Wm. B.....Davis Road
Snapp, Mrs. Richard A.....2644 Chestnut St.
Weinland, Mrs. George C.....R. R. 5
Wickstrom, Mrs. Otto W.....205 Newsom
Wickstrom, Mrs. Otto W., Jr.....3412 Grove Place
Wigh, Mrs. Russell.....2767 Lafayette Ave.
Williams, Mrs. E. W.....1902 Franklin St.
Zaring, Mrs. Byron K.....2419 Riverside Dr.

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Schneider, Mrs. Kenneth D.....Nashville
Seibel, Mrs. Robert M.....Nashville

## BENTON COUNTY

Coddens, Mrs. A. L.....Box 342, Earl Park
McKinney, Mrs. Donald L.....Box 398 Otterbein
Scheurich, Mrs. Virgil..State Rd. 55 South, Oxford

## BOONE COUNTY

### Lebanon

Bennett, Mrs. Kent.....410 E. Fordice
Boyer, Mrs. Don.....129 W. Camp
Coons, Mrs. John D.....121 Ulen Blvd.
Coons, Mrs. Ritchie.....138 Ulen Blvd.
Honan, Mrs. Paul.....202 East Dr.
Kern, Mrs. Clarence G.....1019 N. Meridian
Lenox, Mrs. Jack.....203 East Dr.
McAfee, Mrs. James.....1997 Terrace Lane
Weddle, Mrs. Charles O.....1210 N. East
Wiseheart, Mrs. Robert H.....123 Ulen Blvd.

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Schaaf, Mrs. Alvin D.....Jamestown
Gregg, Mrs. Edwin.....320 E. Main, Thorntown

## CARROLL COUNTY

### Delphi

Baker, Mrs. Eldon E.....R. R. 4, Box 144
Crampton, Mrs. Chas. C.....218 E. Monroe St.
Petry, Mrs. T. Neal.....211 W. North St.
Seese, Mrs. Robert M.....201 W. North St.
Wagoner, Mrs. Geo. W.....305 W. Summit St.

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Adams, Mrs. Max R.....Park Row, Flora
McLaughlin, Mrs. James R.....511 E. Main, Flora
Wise, Mrs. Charles L.....Shangrala, Camden

## CASS COUNTY

### Logansport

Adamski, Mrs. M. S.....614 17th St.
Bailey, Mrs. Earl W.....2522 North
Ballard, Mrs. Charles A.....R. R. 4, Ballard Rd.
Bean, Mrs. Joseph S.....R. R. 1, Box 167
Burnett, Mrs. Paul C.....Logansport State Hosp.
Eckert, Mrs. Russell A.....15 Frederick St.
Fogel, Mrs. Ernest J...Logansport State Hospital
Gatzimos, Mrs. Christos D.....3116 High St. Rd.
Glendening, Mrs. Richard L.....2300 Broadway
Hall, Mrs. Bernard R.....3400 E. Broadway
Harrington, Mrs. James F.....2316 Rolling Ridge
Hillis, Mrs. L. J.....2410 Hastye Hyll
Horning, Mrs. Richard R.
Logansport State Hospital
Jones, Mrs. J. Carl.....R. R. 3
King, Mrs. Jay M.....2319 Mayfair Dr.
Maschmeyer, Mrs. R. H.
Logansport State Hospital
Morrical, Mrs. Russell J.....415 Highland
TerBush, Mrs. Edward L.....R. R. 5
Viney, Mrs. Charles L.....26th and High St.
Wilson, Mrs. Paul H.....2600 Hastye Hyll
Winter, Mrs. Donald K.....2409 Hastye Hyll

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Dutchess, Mrs. Charles T.....Galveston
Flanagan, Mrs. E. P.....106 May, Walton
Lybrook, Mrs. Daniel E.....Young America

## CLARK COUNTY

### Charlestown

Goodman, Mrs. Eli.....333 Oriole Dr.
Jones, Mrs. David.....State Road 39

### Clarksville

Mudd, Mrs. Joseph.....103 Rosewood Dr.
Willner, Mrs. Alan.....214 Rosewood Dr.
Wolverton, Mrs. George.....115 Rosewood Dr.

### Jeffersonville

Buehler, Mrs. George.....Route 1, Utica Pike
Carney, Mrs. J. T.....2602 Hollywood Dr.
Clark, Mrs. William B.....Blackiston Mill Road
Dare, Mrs. Lee.....215 Sparks Ave.
Golden, Mrs. Wm. Y.....1929 Utica Pike
Graham, Mrs. O. P.....713 E. Maple St.
Green, Mrs. Frank, Jr.....201 Kewanna Drive
Havens, Mrs. Alfred Lyle.....1934 Utica Pike
Huoni, Mrs. John.....6 Blanchel Terrace
Isler, Mrs. Nathaniel C.....901 Morningside Dr.
McKechnie, Mrs. Robert K.....Blackiston Mill Rd.
Oca, Mrs. Clemente F.....1452 Altawood Dr.
Reed, Mrs. Edsel.....4 Pawnee Dr.
Roby, Mrs. A. L.....Rt. 9, Box 91, Utica Pike
Shaw, Mrs. Houston.....209 Maplewood Dr.

### Sellersburg

Meyer, Mrs. Claude J.....225 W. Utica St.
Regan, Mrs. George.....303 Indiana
Sturgis, Mrs. Donald G.....542 Linnwood
Vandevert, Mrs. Arthur.....202 Highland

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Carr, Mrs. Joseph.....Pine Rd., Henryville
Greene, Mrs. W. R.....Henryville
Horlander, Mrs. Fridolin.....Henryville

## DEARBORN COUNTY

### Aurora

Baker, Mrs. Leslie M.....204 Fifth St.
Frable, Mrs. Frank.....412 Sunnyside Ave.
Gresham, Mrs. Edwin.....Ebenezer Rd.
Jackson, Mrs. Kenneth.....205 Grant St.
Lindgren, Mrs. Ivan.....Cobbs Hill
Olcott, Mrs. Charles W.....305 Sunnyside

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McNeely, Mrs. Matthew J.....Dillsboro
Fessler, Mrs. Gordon.....Rising Sun

**Lawrenceburg**

Beres, Mrs. Joseph.....105 Meyer Rd.
Bonner, Mrs. Hugh J.....238 Short St.
Bowen, Mrs. Gerald .....24 Parkside Ave.
Conrad, Mrs. Henry.....370 Bielby Rd.
Houston, Mrs. Fred D.....533 Ludlow St.
Hunter, Mrs. Lowell.....2 Clinic Dr.
Morrison, Mrs. George.....107 Billups
Pfeifer, Mrs. James M.....550 Ludlow
Rhodes, Mrs. A. Keith.....Loretta Ave.
Streck, Mrs. Francis A.....547 Ridge Ave.
Weisenberger, Mrs. Brockton L.....912 Bielby Dr.

## DECATUR COUNTY

**Greensburg**

Acher, Mrs. Robert P.....446 E. Washington
Callaghan, Mrs. W. C.....403 Barachel Lane
Dickson, Mrs. Dale D.....700 N. East St.
Miller, Mrs. James C.....178 N. Michigan Ave.
Morrison, Mrs. J. Trevor....161 N. Michigan Ave.
Overpeck, Mrs. Charles.....R. R. 8
Shaffer, Mrs. William R.....214 N. Franklin
Walker, Mrs. Louis A.....R. R. 5

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Porter, Mrs. Edward A.....Westport

## DELAWARE-BLACKFORD COUNTIES

Hurley, Mrs. John.....Daleville
Puterbaugh, Mrs. Karl.....Albany
Montgomery, Mrs. Lall G.
Box 149A, RFD 1, Gaston
Doles, Mrs. Ted.....1102 Progress, Middletown
Egger, Mrs. Ross.....603 N. 12th, Middletown
Owsley, Mrs. Guy...214 N. High St., Hartford City

**Muncie**

A

Adams, Mrs. William B.....W. Jackson St. Pike
Alvey, Mrs. Charles R.....515 Greenbriar Rd.
Anthony, Mrs. Harvey M.....822 W. Charles

B

Ball, Mrs. Clay A.....1015 Linden Ave.
Ball, Mrs. Philip.....2820 W. Main St.
Benken, Mrs. Lawrence.....1511 Riley Rd.
Bergwall, Mrs. Warren.....1507 Riley Rd.
Botkin, Mrs. Clyde G.....2904 Riverside Ave.
Botkin, Mrs. Thomas.....2500 Bethel Pike
Brown, Mrs. Leland.....605 Waid Ave.
Brown, Mrs. Stewart D...R. R. 3, Hamilton Pk.
Brown, Mrs. Thomas.....R. R. 6, Box 191
Burwell, Mrs. Stanley W.....3124 Gilbert
Butz, Mrs. Ralph O.....3824 Riverside Ave.

C

Clark, Mrs. Robert.....3124 University Ave.
Clauser, Mrs. Eldo H.....815 Wayne
Clevenger, Mrs. Joseph H...3124 University Ave.
Cooper, Mrs. John F.....1700 Winthrop Dr.
Covalt, Mrs. Wendell E.....120 Berwyn Rd.
Cullison, Mrs. John.....2601 Parkway Dr.

D

Deutsch, Mrs. William.....3305 Riverside Ave.
Dietz, Mrs. David J.....501 Shellbark
Dunning, Mrs. Thomas.....3 Briar Rd.
Dutchman, Mrs. William R.....1003 N. Shellbark

E-F

Fiederlein, Mrs. Frederick.....308 Wildwood

G

Geckler, Mrs. Charles E.....1007 W. North St.
Gibson, Mrs. Robert.....306 Taft Rd.
Gill, Mrs. Thomas A., Jr.....45 Warwick Rd.
Greiber, Mrs. Marvin.....310 Riley Rd.
Gustafson, Mrs. Milton H.....230 Stradling Rd.

H-I-J

Hall, Mrs. Robert S.....701 Brentwood
Hayes, Mrs. T. R.....19 Warwick Rd.
Henderson, Mrs. Ramon.....75 Warwick Rd.
High, Mrs. Ralph.....2825 University Ave.
Holmes, Mrs. John.....908 W. Gilbert
Hostetter, Mrs. I. S.....300 Winthrop Rd.
Imhof, Mrs. J. D.....46 Warwick Rd.
Judd, Mrs. Donald R.....4 Beckett Dr.

K

Kalker, Mrs. Morton.....704 Greenbriar Rd.
Kammer, Mrs. Walter F.....1005 W. Parkway Dr.
Kim, Mrs. Joon.....1308 Riley Rd.
Kirshman, Mrs. Forrest E.....41 Briar Rd.
Ko, Mrs. Richard.....R. R. 7
Koch, Mrs. Edwin F., Jr.....2904 Ashland
Kress, Mrs. James W.....3839 Riverside Ave.

M-N

Mathewson, Mrs. R. C.....R. R. 6
McCallister, Mrs. Larry.....25 Warwick Rd.
McClintock, Mrs. James A...3121 University Ave.
Montgomery, Mrs. Ralph.....303 Wildwood Lane
Moore, Mrs. Jack.....2005 W. Purdue
Moore, Mrs. Thomas C.....1011 E. Parkway Dr.
Morris, Mrs. J. W.....222 Stradling Rd.
Moss, Mrs. M. J.....1010 W. Parkway Dr.
Neece, Mrs. Gus W.....2501 W. Washington St.
Nelson, Mrs. Harold E.....3216 Torquay Rd.

O

Osborne, Mrs. John.....3119 Petty Road
Owens, Mrs. Thomas.....608 E. Charles

P-Q

Peacock, Mrs. Robert.....R. R. 3
Pippinger, Mrs. Joseph.....2200 Twickingham Dr.
Pippinger, Mrs. W. G.....1200 N. Tillotson
Quick, Mrs. William J.....Moore Rd., R. R. 7

R

Rettig, Mrs. Arthur.....614 N. McKinley Ave.
Rivers, Mrs. Glynn.....307 Alden Rd.

S

Schulhof, Mrs. M. G.....921 W. Parkway Dr.
Searight, Mrs. Howard.....1125 Bittersweet Dr.
Speck, Mrs. Carlson.....3208 University
Stanley, Mrs. John R.....2303 Redding
Steele, Mrs. Frank M.....421 Bittersweet
Stibbins, Mrs. Warren E.....609 Brentwood
Stout, Mrs. Francis E.....102 Berwyn Rd.
Stump, Mrs. Richard.....1019 W. North St.

T

Taylor, Mrs. Donald.....8 Wildwood Lane
Tharp, Mrs. Donald.....3121 Petty Rd.
Tomlin, Mrs. Hugh M.....2920 Beechwood Ave.

V-W

Venis, Mrs. Kemper.....2508 White River Rd.
Voss, Mrs. Gert.....77 Warwick Rd.
Ware, Mrs. Herbert.....1700 Glen Ellyn
Wince, Mrs. Leland.....1709 Northfield

Y

Young, Mrs. G. S.....114 Berwyn Rd.

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Hinchman, Mrs. Jean.....Parker
Hill, Mrs. Robert.....Yorktown
Walker, Mrs. Jack.....R. R. 1, Yorktown

## DUBOIS COUNTY

Barrow, Mrs. John H.....Dale, P. O. Box 128
Backer, Mrs. Henry George..Ohio St., Ferdinand
Bland, Mrs. Jack D.....Holland
Erhart, Mrs. Herbert G.....Ferdinand

### Huntingburg

Bretz, Mrs. John.....Orchard Ridge
Scales, Mrs. Alfred B.....Holland Rd.
Scales, Mrs. Allen D.....Cedar Heights
Stork, Mrs. Harvey K.....523 First St.

### Jasper

Beaven, Mrs. John.....W. 13th St.
Benages, Mrs. Anthony.....948 MacArthur
Gootee, Mrs. Francis.....R. R. 1
Gootee, Mrs. Thomas.....1328 Dorbett St.
Heck, Mrs. Martin C.....408 W. 15th
Held, Mrs. George A.....716 W. Ninth
Klamer, Mrs. Charles H.....616 W. 13th St.
Ploetner, Mrs. Edward.....1344 Dorbett St.
Salb, Mrs. J. P.....R. R. 5
Wagner, Mrs. Arthur L.....825 W. 13th St.

## ELKHART COUNTY

### Bristol

Neidballa, Mrs. E. G.....R. R. 1
Schlosser, Mrs. H. C.
Seven Gables, W. Vistula St., Box 57

### Elkhart

Atwood, Mrs. Wm. H., Jr.....320 Cedar St.
Bender, Mrs. Robert L.....300 Robair Lane
Benson, Mrs. James E...1629 Rainbow Bend Blvd.
Billings, Mrs. Elmer R.....2022 E. Jackson Blvd.
Bloom, Mrs. George R.....1100 E. Jackson Blvd.
Boling, Mrs. Richard C.....217 Riverdale Dr.
Bowdoin, Mrs. George E.....3809 Greenleaf Blvd.
Campbell, Mrs. Patrick B.....1517 Meadow Lane
Classen, Mrs. Pete R. C...Prairie St. Road, R.R. 4
Compton, Mrs. Walter A.....2225 Greenleaf Blvd.
Conklin, Mrs. Raymond L...215 Swanson Circle W.
Cormican, Mrs. Herbert L.
1950 Rainbow Bend Blvd.
Dovey, Mrs. Edward G., Jr...1604 Springbrook Dr.
Durham, Mrs. Thomas E.....135 S. Vine St.
Echeverria, Mrs. Rodolfo E.....707 Hiawatha Dr.
Elliott, Mrs. Thomas A.....2001 Stevens Ave.
Finfrock, Mrs. James D.....608 S. West Blvd.
Fleming, Mrs. Claude F.....229 W. Jackson Blvd.
Futterknecht, Mrs. James O...2313 Morehouse Ave.
Gattman, Mrs. G. Beach.....1319 Lawn Ave.
Hannah, Mrs. Jack W.....1906 E. Jackson Blvd.
Heminway, Mrs. Norman L.
1700 Rainbow Bend Blvd.
Horswell, Mrs. R. G.....1629 E. Jackson Blvd.
Hull, Mrs. Arthur W.....3333 Greenleaf Blvd.
Hurley, Mrs. James William.....3439 Calumet
Jones, Mrs. Robert B.....1833 Rainbow Bend Blvd.
Keating, Mrs. John U.....1416 Strong Ave.
Kesim, Mrs. Mufit Husam.....821 Hiawatha Dr.
Kintner, Mrs. Burton E.....3520 E. Jackson Blvd.
Kistner, Mrs. Arthur W.....R. R. 3, Box 81
Klassen, Mrs. Otto Dyck.....R. R. 4, Box 504
Koehler, Mrs. Elmer George..615 N. Riverside Dr.
Krause, Mrs. Frederick.....1001 St. Clair St.
Luther, Mrs. William C.....1422 Kilbourn St.
Lundt, Mrs. Milo O.....519 S. Second St.
Mark, Mrs. George A.....908 Strong
Markel, Mrs. Ivan J.....215 W. Franklin St.
Martin, Mrs. Paul H.....1519 Strong Ave.
Miller, Mrs. Donald G.....4634 W. Indiana Ave.
Miller, Mrs. Galen R.....2229 Thorndale Ct.
Miller, Mrs. Hugh A., Jr.....417 Prospect St.
Miller, Mrs. Samuel T.....174 Witmer Ave.
Mininger, Mrs. Edward P...1118 E. Jackson Blvd.
Mishkin, Mrs. Irving....1809 Rainbow Bend Blvd.
Paff, Mrs. Wm. A.....1745 Rainbow Bend Blvd.
Paine, Mrs. George E.....329 Meisner Ave.
Pancost, Mrs. Vernon K.....160 Riverview Ave.
Parshall, Mrs. Dale B.....3538 Gordon Rd.
Pletcher, Mrs. William D.....405 S. 2nd St.
Rouen, Mrs. Robert L.....2002 E. Jackson Blvd.
Rupe, Mrs. Lloyd O.....R. R. 4, Oakland Ave. Rd.
Rupel, Mrs. Dennis F.....3100 Benham Ave.
Sears, Mrs. Murray M.....4806 W. Indiana Ave.
Silber, Mrs. David L.....1501 Fulton St.
Soaje-EchAgue, Mrs. Eliseo..410½ W. Franklin St.
Spray, Mrs. Page E.....658 Kilbourn St.
Stubbins, Mrs. William...1703 Rainbow Bend Blvd.
Swihart, Mrs. Danny D.....1219 Greenleaf Blvd.
Swihart, Mrs. Homer R.....1621 E. Jackson Blvd.
Wilson, Mrs. Orley E.....2505 Greenleaf Blvd.
Work, Mrs. James A., Jr.....4 St. Joseph Manor
Yoder, Mrs. C. Richard.....409 Prospect St.
Zeitler, Mrs. Philip S.....1509 Meadow Lane

### Goshen

Bender, Mrs. John M.....1303 E. Douglas St.
Bigler, Mrs. Frederick W.....124 Parmley Dr.
Chandler, Mrs. Leon H.....412 S. Fifth St.
Freeman, Mrs. Floyd M.....309 E. Washington St.
Gorham, Mrs. Charles E.....118 Gorham
Graber, Mrs. Virgil R.....R. R. 2, Box 107
Haney, Mrs. Leslie.....R. R. #3
Hostetler, Mrs. Carl M.....1602 S. Eighth St
Kennedy, Mrs. Myron S.....1503 West Ave.
Krabill, Mrs. Willard S.....120 Carter Ave.
Martin, Mrs. Floyd S.....2301 S. Main St.
Massanari, Mrs. Walter S.....211 Egbert Rd.
Smucker, Mrs. Ernest E.....R. R. 5, Bluff Rd.
Troyer, Mrs. Dana O.....1727 S. 13th St.
Troyer, Mrs. George W.....1204 S. 8th St.
Turner, Mrs. John P.....507 Greene Road
Westfall, Mrs. George S.....2422 S. Main St.

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Yoder, Mrs. Jonathan G..103 Brown St., Middlebury

### Nappanee

Kendall, Mrs. F. M.....654 Woodland
Price, Mrs. Douglas W.....607 E. Van Buren
Wenger, Mrs. James E.....106½ Market St.

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Quilty, Mrs. Thomas J.....R. R. 1, New Paris
DeFries, Mrs. John J.....New Paris
Fosbrink, Mrs. E. L.....218 S. Huntington,
Box 157, Syracuse

### Wakarusa

Abel, Mrs. Robert.....105 E. Harrison
Guttman, Mrs. John B. .....109 Broadview Dr.
Miller, Mrs. James R.....P. O. Box 421

## FAYETTE-FRANKLIN COUNTIES

### Brookville

Foreman, Mrs. Walter A.....617 Main
Seal, Mrs. Perry F.....901 Main
Smith, Mrs. H. N.....812 Main

### Connersville

Ashworth, Mrs. Louis N.....2027 Indiana Ave.
Clark, Mrs. Helen Nevin.....401 Western Ave.
Ellis, Mrs. George M.....108 East 10th St.
Gregg, Mrs. Albert F.....900 Oak St.
Hudson, Mrs. Arlington M.....80 East Dr.
Kauffman, Mrs. Robert W.....R. F. D. 2
Kerrigan, Mrs. William F. .....R. F. D. 6
Lockhart, Mrs. Jack M.....54 West Dr.
Mountain, Mrs. Francis B.....1720 Virginia Ave.
Neukamp, Mrs. Frank H.....R. R. 6

Sanders, Mrs. Bertram W.....1533 Virginia Ave.
Steinem, Mrs. Joseph L.....R. R. 3
Watterson, Mrs. Gerald T.....1704 Virginia Ave.

## FLOYD COUNTY

### Jeffersonville

Baxter, Mrs. S. M.....3100 Centralia Ct.
Gentile, Mrs. John P.....3405 Centralia Ct.
McCullough, Mrs. J. Y.....3500 Centralia Ct.
Sloan, Mrs. Herbert.....213 Lynnwood, Lincoln Heights

### New Albany

Baker, Mrs. A. M.....2523 Glenwood Ct.
Baxter, Mrs. J. W., Jr.....426 Woodrow Ave.
Best, Mrs. Maurice M.....1233 Vance Ave.
Bickers, Mrs. Everett E.....3325 Buffalo Trails
Brown, Mrs. K. H.....1654 Hedden Park
Buchman, Mrs. Marshall.....1824 State St.
Cannon, Mrs. Daniel H.....1203 E. Spring St.
Edwards, Mrs. W. F.....615 Beharrel Ave.
Garner, Mrs. Wm. H., Sr.....922 E. Spring St.
Garner, Mrs. William H., Jr.....1510 Sunset Dr.
Geyer, Mrs. Joseph H.....Silvercrest Hospital
Hess, Mrs. P. Patrick.....1313 Ridgeway Ave.
Higgins, Mrs. John R.
Old Vincennes Rd., R. R. 2, Box 504
LaFollette, Mrs. Donald R...1224 Westwood Lane
LaFollette, Mrs. Robert E.....2515 Glenwood Ct.
Nedelkoff, Mrs. Bogdan.....R. R. 2, Box 500
Paris, Mrs. John M.....2003 Lindbergh Ct.
Pierce, Mrs. Gene S.....1425 Bellmeade Dr.
Robertson, Mrs. A. N.....323 E. Ninth St.
Ruoff, Mrs. William.....1109 Lafayette Dr.
Sonne, Mrs. Irvin H.....1607 Hedden Court
Streepey, Mrs. Jefferson I.....1919 DePauw Ave.
Voyles, Mrs. Harry.....425 Beharrel Ave.
Wallace, Mrs. Elmer L.....1804 DePauw Ave.
Wolfe, Mrs. Morton F.....2533 Glenwood Ct.
Wolfe, Mrs. Nelson A.....Graybrook Lane
Worley, Mrs. H. L.....1923 DePauw Ave.
Youngs, Mrs. Paul.....308 Ellen Ct.

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Engleman, Mrs. Harry K.....Georgetown
Cook, Mrs. Melvin..62 N. Hill Drive, Floyds Knobs

## FULTON COUNTY

Miller, Mrs. Virgil C.....P. O. Box 37, Akron
Stinson, Mrs. Arthur E.....Athens
Kraning, Mrs. Kenneth K.
834 West Shore Dr., Culver

### Rochester

Dielman, Mrs. Franklin C.....920 Jefferson St.
Herendeen, Mrs. Elbie V.....317 W. Seventh St.
King, Mrs. Milo O.....110½ E. Eighth St.
Knockel, Mrs. Wayne.....1115 Washington St.
Richardson, Mrs. Chas. L.....R. R. 2, Box 276
Richardson, Mrs. Joseph D.....506 Pontiac St.
Rowe, Mrs. Howard H.....417 W. Ninth St.
Rusler, Mrs. William J.....R. R. 2
Stinson, Mrs. Dean K.....1318 Main St.

## GIBSON COUNTY

Geick, Mrs. Raymond G...207 N. Main, Ft. Branch
Marchand, Mrs. Edwin V.....Haubstadt

### Oakland City

Clark, Mrs. Carl M.....123 Vine St.
Dye, Mrs. William E.....518 S. Jackson St.
Wood, Mrs. Russell W.....High St.

### Princeton

Carpentier, Mrs. Harry F.....319 E. State St.
Folck, Mrs. John K.....528 N. Main St.
Graves, Mrs. Orville M.....125 W. Walnut St.
McCarty, Mrs. Virgil.....403 W. Spruce St.
McElroy, Mrs. Robert S.....404 W. Walnut St.
Peck, Mrs. James F.....605 W. Monroe St.
Weitzel, Mrs. Roland E.....309 W. Spruce St.
Wells, Mrs. William R.....Broadview Addition

## GRANT COUNTY

### Marion

Abell, Mrs. Charles F.....915 Wabash Ave.
Adams, Mrs. Luther.....V.A. Hospital
Alderfer, Mrs. Henry.....919 Euclid Ave.
Ansbacher, Mrs. Stefan.....R. R. 1
Ayres, Mrs. W. W.....820 Jeffras Ave.
Bailey, Mrs. Douglas.....1316 Elm Lane
Bloom, Mrs. A. Ward.....610 River Rd.
Braunlin, Mrs. Robert.....P.O. Box 467
Brown, Mrs. Robert M.....825 Euclid Ave.
Comeau, Mrs. Wm. J.....918 Hawthorne
Cunningham, Mrs. Robert.....1017 Euclid Ave.
Davis, Mrs. Joseph B.....1315 Sheridan Rd.
Davis, Mrs. Merrill S.....723 Euclid Ave.
Davis, Mrs. Richard.....1119 Overlook Rd.
Donaldson, Mrs. Miles.....1116 Spencer Ave.
Dunbar, Mrs. Fred.....902 Hawthorne Rd.
Eshleman, Mrs. L. H.....129 N. Washington
Fisher, Mrs. Henry.....R. R. 4
Fuelling, Mrs. James.....R. R. 2
Ganz, Mrs. Max.....904 Jeffras Ave.
Goldsmith, Mrs. David.....1225 Jeffras Ave.
Grant, Mrs. Arthur M.....3602 Wildwood Dr.
Hover, Mrs. Galen M.....27 A Veterans Hosp.
Hartvigsen, Mrs. H. Dean.....V.A. Hospital
Huff, Mrs. Asher.....110 North E. St.
Hummel, Mrs. R. M.....2411 Lommel Lane
Jarrett, Mrs. John C.....3418 Wildwood Dr.
Lahr, Mrs. Richard.....815 Jeffras Ave.
Langrall, Mrs. Harrison M.....715 Crossway
Larzelere, Mrs. Henry.....121 N. Washington
Lavengood, Mrs. Russell W.....Charles Rd. R. R.
Lonngren, Mrs. Dudley.....611 Cardinal Lane
Love, Mrs. V. Logan.....808 Crossway
Miller, Mrs. H. Allison.....1010 W. Fourth St.
Pattison, Mrs. John D.....1315 Elm Lane
Pearcy, Mrs. Marcene.....712 Buckingham Dr.
Powell, Mrs. J. P.....127 River Dr.
Reid, Mrs. James D.....505 Buckingham Dr.
Renbarger, Mrs. Lester.....2111 Wabash Pike
Rhamy, Mrs. Arthur.....1230 Euclid Ave.
Rhorer, Mrs. John G.....711 Wabash Ave.
Richardson, Mrs. Jos. H.....911 River Dr.
Schroeder, Mrs. Robert W.....2123 S. Boots St.
Simmons, Mrs. Frederick H.....2607 Beech Lane
Skomp, Mrs. Claud E.....1123 Euclid Ave.
Smith, Mrs. Barton T.....1005 Audubon Dr.
Snowhite, Mrs. Arthur.....610 Cardinal Lane
Stenger, Mrs. R. H.....227 North E. St.
Thompson, Mrs. B. Jay.....123 River Dr.
Warren, Mrs. Carroll B.....1211 Euclid Ave.
Wilson, Mrs. Ned.....1509 Matter Park Rd.
Woodbury, Mrs. J. W.....709 W. 4th
Young, Mrs. Robert G.....1207 Northwood Dr.

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Malott, Mrs. Fred.....Converse
Yale, Mrs. Charles.....Fairmount
Garrison, Mrs. L. J.....515 E. Main St., Gas City
Koontz, Mrs. William A.....334 E. Main, Gas City
Shoemaker, Mrs. Richard L.....211 E. South "A," Gas City
Baskett, Mrs. R. J.....412 S. Main St., Jonesboro
Taylor, Mrs. E. C.....Upland
Rifner, Mrs. Eugene.....Van Buren
McIlwain, Mrs. Robert.....Warren

## HAMILTON COUNTY

Karlick, Mrs. Joseph R.....Arcadia
Thomas, Mrs. W. Clayton
80 4th Ave. S.E., Carmel
Havens, Mrs. Oscar.....R. R. 1, Cicero

### Noblesville

Ambrose, Mrs. J. C.....298 N. Ninth St.
Blackburn, Mrs. Howard..14010 Allisonville Rd.
Hash, Mrs. John S.....R. R. 4
Haywood, Mrs. John G.....Craig Highlands
Kraft, Mrs. Haldon C.....15075 Allisonville Rd.
Lanning, Mrs. R. Adrian.....R. R. 2
Lloyd, Mrs. Joe R.....559 Sunset Dr.
Shanks, Mrs. Ray W.....1507 Logan St.

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Manhart, Mrs. Doyle B.....R. R. 2, Sheridan
Newby, Mrs. Eugene.....R. R. 1, Sheridan
Waitt, Mrs. Paul.....406 E. Fifth St., Sheridan
Connoy, Mrs. Andrew.....Westfield
Connoy, Mrs. Leo....139 N. Union St., Westfield

## HANCOCK COUNTY

Johnston, Mrs. W. R.....Charlottesville
Scott, Mrs. Robert.....Charlottesville
Garrison, Mrs. James.....Cumberland
Rhynearson, Mrs. Hal R...235 Merrill St., Fortville

### Greenfield

Allen, Mrs. Joseph.....210 E. Lincoln
Beeson, Mrs. Wilbur.....209 N. Penn
Endicott, Mrs. Wayne.....115 McClelland
Farrell, Mrs. John J., Jr.....North St., Rd. 9
Hunter, Mrs. Donn R.....830 Oak Blvd.
Kinneman, Mrs. Robert E.....120 McClelland Dr.
Kirby, Mrs. Ted C.....122 Grandison Rd.
Moenning, Mrs. John.....244 W. Walnut
Rea, Mrs. Ralph L.....Greenfield
Smith, Mrs. John H.....144 Grandison Rd.
Vingis, Mrs. Bronie A.....705 N. State St.
Woods, Mrs. James R.....715 N. East St.

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Freeborn, Mrs. Warren
11626 Indian Creek Rd., Indianapolis
Pierson, Mrs. Thomas A.....New Palestine
Cagle, Mrs. Robert.....New Palestine
Miller, Mrs. Joseph A.....R. R. 12, Box 230 Y, Oaklandon
Kuhn, Mrs. Robert.....Wilkinson

## HENDRICKS COUNTY

Black, Mrs. James...8 Green Acre Ct., Brownsburg
Foltz, Mrs. Lloyd.....North Ridge, Brownsburg
Scudder, Mrs. A. N.....24 N. Grant, Brownsburg
Walker, Mrs. Thomas..Fairfield Hts., Brownsburg

### Danville

Chase, Mrs. Thomas P.....R. R. 1, Box 117-C
Cheesman, Mrs. Donald D.....37 Orchard Lane
Gibbs, Mrs. Joseph W.....445 E. Mill St.
Heinlein, Mrs. Carl L.....540 S. Cross
Kirtley, Mrs. Robert W.....R. R. 3, Box 196
Koch, Mrs. Elmer.....301 S. Bowen
Terry, Mrs. Lloyd.....292 W. Marion

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Ellis, Mrs. L. Hall.....Lizton
Karpel, Mrs. Bernard.....R. R., Mooresville
Scamahorn, Mrs. Malcolm O.....Pittsboro

### Plainfield

Aiken, Mrs. Milo M.....140 N. Center
Cohen, Mrs. Irving.....645 E. Main St.
Haggard, Mrs. David B.....R. R. 2, Box 232
Stafford, Mrs. William C.....625 S. East St.
Warbinton, Mrs. Fred P.....680 Avon Rd.

## HENRY COUNTY

### New Castle

Amos, Mrs. Robert L.....924 Lincoln Ave.
Bitler, Mrs. Clyde.....603 S. 11th St.
Bledsoe, Mrs. James.....Hillsboro Rd.
Brock, Mrs. J. T.....St. Rd. 36 East
Burnett, Mrs. Arthur B.....801 Melody Lane
Cain, Mrs. David R.....3701 S. Memorial Dr.
Das, Mrs. Amal K.....100 Van Nuys Rd.
Davies, Mrs. Robert R.....1125 Audubon Rd.
Dye, Mrs. Cloyd L.....R. R. 5
Easter, Mrs. James N.....1112 Audubon Rd.
Fisher, Mrs. John E.....1135 Woodlawn Dr.
Foster, Mrs. Ray T.....420 N. Main St.
Harrison, Mrs. Benjamin L.....233 Bundy Ave.
Heilman, Mrs. William C., Jr...1112 St. James Ct.
Hill, Mrs. Kenneth G.....707 Lelene
Iterman, Mrs. George.....729 I Ave.
Kennedy, Mrs. W. U.....701 S. 14th St.
Life, Mrs. Homer L.....1107 St. James Ct.
McClelland, Mrs. Harry N.....New Castle
McDonald, Mrs. Frank C.....527 S. Main St.
McElroy, Mrs. James S.....1213 Audubon Rd.
McKee, Mrs. Roy.....Parkplace
Murray, Mrs. William E.....100 Van Nuys Rd.
Saint, Mrs. William.....705 Hawthorn Rd.
Smith, Mrs. Mark.....631 S. 11th St.
Steussy, Mrs. Calvin N.....601 Hoosier Dr.
Stout, Mrs. Walter M.....1103 Audubon Rd.
Stricker, Mrs. Paul J.....719 Fair Oaks Dr.
Thorne, Mrs. Charles E.....1225 Audubon Rd.
Vivian, Mrs. Donald E.....2715 Fair Oaks Dr.
Wiggins, Mrs. D. S.....219 S. 12th St.

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Clark, Mrs. M. E.....Cambridge City
Hollenberg, Mrs. A. E.
105 N. Franklin St., Hagerstown
Wiatt, Mrs. Leonard H.
108 N. Wash. St., Knightstown
Scheetz, Mrs. Marion R.....Lewisville
Stauffer, Mrs. George E.....Mooreland
Marshall, Mrs. Lloyd....Walnut St., Mt. Summit
Robertson, Mrs. William S.....213 W. Main St., Spiceland

## HOWARD COUNTY

Smith, Mrs. Charles..R. R. 1, Box 652M, Carmel
Denton, Mrs. Larkin D....S. Meridian, Greentown
Shoup, Mrs. E. M.....R. R. 2, Willow Acres, Greentown

### Kokomo

Adams, Mrs. C. J.....1216 W. Superior
Althoff, Mrs. William.....2501 S. Wabash
Alward, Mrs. J. H.....401 W. Walnut
Artis, Mrs. Myrle E.....900 E. Broadway
Ault, Mrs. Carl H.....3015 Dellwood Dr.
Boughman, Mrs. Joe.....1610 W. Taylor
Bowers, Mrs. Copeland C.....1530 W. Taylor
Bowers, Mrs. Garvey B.....421 Morningside
Bowers, Mrs. John A.....1535 W. Jefferson
Bradley, Mrs. Richard V.....3210 Janice Dr.
Bruegge, Mrs. Theodore J.....2225 S. Wabash
Cattell, Mrs. Lee M.....1235 W. Sycamore
Clarke, Mrs. Elton R.....4320 W. Sycamore
Conley, Mrs. Thomas M.....2811 Dellwood Dr.
Craig, Mrs. R. A.....4105 W. Sycamore Rd.
Craig, Mrs. Reuben.....410 S. Hickory Lane
Cuthbert, Mrs. F. S.....1027 W. Walnut
DeBrota, Mrs. John, Jr.....3114 Orleans Ct.
Earl, Mrs. Max M.....2210 S. Wabash
Elleman, Mrs. Jack.....414 W. Mulberry
Ericson, Mrs. Homer S.....124 Leafy Lane
Farrell, Mrs. T. Edwin.....3816 Red Bud Lane
Ferry, Mrs. Paul W.....1207 W. Sycamore
Fields, Mrs. Donald L.....3021 Mayfair
Frazier, Mrs. Jack L.....2318 S. Wabash

Fretz, Mrs. Richard C.....4701 Mayfield Dr.
Golper, Mrs. Marvin N.....411 Morningside Dr.
Good, Mrs. Richard P.....227 N. Forest Dr.
Grothouse, Mrs. Carl B.....515 Rainbow Dr.
Guin, Mrs. Jere D.....403 W. Lincoln Rd.
Halfast, Mrs. Richard W.....2505 Katherine Ave.
Harshman, Mrs. James.....4400 Mayfield Dr.
Hutto, Mrs. William H....4815 West Sycamore Rd.
Jewell, Mrs. G. M.....1318 W. Sycamore
Kremers, Mrs. George A.....2401 S. Wabash
Lehman, Mrs. David P.....4501 Parkway
Longshore, Mrs. Robert E.....145 Westmoreland
McClure, Mrs. Warren N.....309 Lody Lane
McIndoo, Mrs. R. E.....820 W. Walnut
Mendelson, Mrs. Stanley M.....2325 S. Wabash
Michael, Mrs. Robert L.....4610 W. Sycamore Rd.
Moore, Mrs. John M.....813 Melody Lane
Morrison, Mrs. W. R.....413 Conradt Ave.
Murray, Mrs. Ernest C.....2200 S. Webster
Paris, Mrs. Durward W.....2417 S. LaFountain
Perkins, Mrs. P. L.....Miller Wood Lane
Phares, Mrs. Robert W.....1712 S. Malfalfa Rd.
Prather, Mrs. Philip E.....123 Magnolia Dr.
Radpour, Mrs. Shokri.....4509 Mayfield Dr.
Rinehart, Mrs. James.....2504 Katherine
Rudicel, Mrs. Max W.....321 Kingston Rd.
Schwartz, Mrs. F. C.....5015 W. Sycamore Rd.
Shenk, Mrs. Earl M.....306 N. Webster
Sorenson, Mrs. Raymond..4301 Miller Wood Lane
Townley, Mrs. Normand.....5912 Yale Blvd.
Wachob, Mrs. Tom W., Jr.....806 James Dr.
Wible, Mrs. James H.....2705 W. Jefferson Rd.
Wilson, Mrs. Norman K.....3201 Janice Dr.

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Evans, Mrs. Robert W.....Russiaville

## HUNTINGTON COUNTY

### Huntington

Brubaker, Mrs. Harold S.....721 Flaxmill Rd.
Casey, Mrs. Stanley M.....408 E. Market St.
Clark, Mrs. Joseph H.....R. R. 9
Cope, Mrs. Stanton E.....1022 N. Jefferson St.
Doermann, Mrs. Paul E.....1522 Cherry St.
Eviston, Mrs. J. Boyd.....1362 Poplar St.
Gill, Mrs. D. Richard.....6 Northway Dr.
Grayston, Mrs. Wallace S.....303 E. Market St.
James, Mrs. Thomas, Jr.....1044 Poplar St.
Marks, Mrs. Howard H.....1120 N. Jefferson St.
Meiser, Mrs. Robert D.....1738 Cherry St.
Miller, Mrs. Wayne S.....R. R. 8
Mitman, Mrs. Floyd B.....1470 Poplar St.
Peare, Mrs. Reeve B.....1517 Cherry St.
Van Campen, Mrs. Warren.....1137 Cherry
Wagner, Mrs. Richard W.....Old Andrews Rd.
Wheeler, Mrs. Barth E.....418 Etna Ave.

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Cooper, Mrs. B. Trent.....Roanoke
Bennett, Mrs. J. B.....Warren

## JACKSON-JENNINGS COUNTIES

### Brownstown

Gillespie, Mrs. G. R.....710 Commerce
Scharbrough, Mrs. William.....R. R. 2
Shields, Mrs. Jack.....721 W. Spring
Shortridge, Mrs. Wilbur.....R. R. 1

### Crothersville

Adair, Mrs. W. K.....208 S. Armstrong
Bard, Mrs. Frank B.....305 E. Howard

### North Vernon

Berkshire, Mrs. Shaffer.....121 W. Long St.
Calli, Mrs. Louis J.....408 S. State
Ellis, Mrs. Forrest D.....130 W. Long St.
Johnson, Mrs. William A.....318 Jennings St.

### Seymour

Baxter, Mrs. Harry..710 West Dr., Sunset Pkwy.
Black, Mrs. J. M...671 Braewick Rd., Sunset Pkwy.
Bobb, Mrs. Kenneth E.....465 Lasher Dr.
Bosch, Mrs. Ralph O..930 South Dr., Sunset Pkwy.
Day, Mrs. Durbin.....515 W. Sixth St.
Graessle, Mrs. H. P...640 East Dr., Sunset Pkwy.
Kamman, Miss Martha.....332 W. Oak St
Martin, Mrs. Guy.....1408 Ewing St.
Ripley, Mrs. John W.....2001 Ewing St.
Templeton, Mrs. Ian.....348 Carter Blvd.
Wiethoff, Mrs. C. A...615 West Dr., Sunset Pkwy.

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Knotts, Mrs. Slater.....R. R. 3, Columbus

## JASPER COUNTY

Schantz, Mrs. Richard
418 S. Kentucky St., Remington

### Rensselaer

Beaver, Mrs. Raymond E.....111 Thompson St.
Jones, Mrs. Edwin F.....406 Milton
O'Brien, Mrs. Francis E.....530 Park Ave.
Ockerman, Mrs. Kenneth R.....202 Home St.
Williams, Mrs. Paul A.....402 N. Weston St.

## JAY COUNTY

Andrews, Mrs. Frank.....R. R. 2, Geneva
Donnally, Mrs. George.....R. R. 1, Geneva
Pretorius, Mrs. Walter.....Fort Recovery, Ohio
Shroyer, Mrs. Herbert.....R. R. 2, Dunkirk

### Portland

Cripe, Mrs. William H.....507 W. High St.
Fitzpatrick, Mrs. James S.....405 W. Race St.
Gillum, Mrs. Eugene.....W. Votaw St
Keeling, Mrs. F. E.....609 W. Race St.
Lopez, Mrs. Alfonso.....1160 W. Walnut St.
Schenck, Mrs. Ralph.....R. R. 2, W. 7th St.
Spahr, Mrs. Donald E.....615 W. Race St.
Steffy, Mrs. Ralph M.....321 E. Race St.
Vormohr, Mrs. Joseph F.....1011 S. Meridian St.

## JOHNSON COUNTY

### Franklin

Andrews, Mrs. Hugh K.....R. F. D. 4
Bullers, Mrs. Robert C.....395 S. Home Ave.
Bullington, Mrs. George.....R. F. D. 4
Chappel, Mrs. A. T.....1101 North Dr.
Deppe, Mrs. Charles F.....1215 Park Ave.
Ferrara, Mrs. Joseph F.....1000 E. King St.
Foster, Mrs. R. H. K.....1025 Orchard Lane
Harvey, Mrs. Harry.....Methodist Home
Hibbs, Mrs. W. G.....R. F. D. 1
Jones, Mrs. Charles A.....1010 E. Adams Dr.
Mock, Mrs. Harry E.....201 E. Monroe St.
Murphy, Mrs. Harry E.....150 N. Main St.
Portteus, Mrs. Walter L.....R. R. 2
Province, Mrs. Wm. D.....51 N. Water St.
Records, Mrs. Arthur W.....216 E. Jefferson St.
Records, Mrs. John M.....1138 Orchard Lane
Ritteman, Mrs. George.....R. R. 3, Box 19A
Stogsdill, Mrs. W. W.....R. R. 4
Walters, Mrs. Jack L.....1205 E. Jefferson St.
Wesemann, Mrs. Merrill M.....17 Morning Dr.

### Greenwood

Brown, Mrs. George E.....404 Beech Park Dr.
Link, Mrs. Charles.....208 S. Fairview
Machledt, Mrs. John.....243 S. Madison Ave.
Ogle, Mrs. Robert.....474 W. Wiley

Sheek, Mrs. Kenneth I.....407 S. Forest Dr.
Snodgrass, Mrs. Robert.....480 Beech Park Dr.
Tiley, Mrs. George.....40 N. Madison
Young, Mrs. Joseph W.....904 Beech Park Dr.

## KNOX COUNTY

### Vincennes

Anderson, Mrs. John B.....1202 Busseron St.
Anderson, Mrs. Richard M.....Monroe City Rd.
Arbogast, Mrs. Paul B.....1420 Old Orchard Rd.
Barrett, Mrs. Thomas L.....2520 Old Orchard Rd.
Bartlett, Mrs. Donald T.....1315 McDowell Rd.
Black, Mrs. Boyd K.....1008 State Road 67-N
Cantwell, Mrs. E. R.....862 Ridgeway
Chattin, Mrs. Herbert O.....729 Main St.
Coffel, Mrs. Melvin H.....Simpson Lake
Corsentino, Mrs. Bart E.....110 State Road 67
Curtner, Mrs. Myron L.....216 N. Sixth St.
Edwards, Mrs. Edward T., Jr.....702 Vigo St.
Ewing, Mrs. N. D.....Monroe City Rd.
Hendrix, Mrs. Charles.....1202 E. Sycamore
Humphreys, Mrs. Joe E.....1602 Weed Lane
McCormick, Mrs. Hubert D.....518 N. Fourth St.
McDowell, Mrs. M. M.....1322 Audubon Rd.
McMahan, Mrs. V. C.....Monroe City Rd.
Miller, Mrs. Charles L.....P. O. Box 201
Nichols, Mrs. Robert J.....1906 John R. Rd.
Parmenter, Mrs. Harry B.....205 Elm Lane
Reilly, Mrs. James F.....401 Buntin St.
Shaffer, Mrs. Kenneth L.....2600 Ridge Rd.
Shanklin, Mrs. Jack L.....1545 Barnett Lane
Smith, Mrs. S. Joseph.....504 N. Fourth St.
Spencer, Mrs. Frederic.....902 Perry St.
Stein, Mrs. Richard H.....1209 Old Orchard Rd.
Stewart, Mrs. Frank W.....Hillcrest Rd.
Sullenger, Mrs. A. A.....803 Seminary
Vaughn, Mrs. Walter R.....2018 Prospect Ave.
Von der Lieth, Mrs. William C....Monroe City Rd.
Welch, Mrs. Norbert M.....Monroe City Rd.

## KOSCIUSKO COUNTY

Gill, Mrs. D. D.....R. R. 2, Leesburg
Urschel, Mrs. Dan L.....Mentone
Wilson, Mrs. Wymond B...P. O. Box 421, Mentone
Hursey, Mrs. Virgil G.....Milford
Pierson, Mrs. Pearl H.....R. R. 1, Silver Lake
Baum, Mrs. John R.....307 7th St., Winona Lake
Snider, Mrs. Roland S. .....1108 Court St., Winona Lake

### Warsaw

Arford, Mrs. John E.....1319 E. Center St.
Cron, Mrs. William J.....1548 Country Club Dr.
Dormire, Mrs. Robert.....R. R. 2
Hashemi, Mrs. Hossein.....1306 Ranch Rd.
Haymond, Mrs. George M...945 Country Club Dr.
Hogle, Mrs. Frank.....R. F. D. 2
Keough, Mrs. Thomas F.....320 N. Lake St.
Laird, Mrs. L. A.....1816 E. Sheridan
Loudermilk, Mrs. Richard G.....311 W. Center St.
Murphy, Mrs. Samuel C.....216 South High St.
Reed, Mrs. E. A.....1219 E. Main St.
Shrader, Mrs. Carl.....Spring Hill Acres
Thomas, Mrs. E. Winton.....711 E. Main St.

## LAKE COUNTY

### Cedar Lake

Babcoke, Mrs. Gary.....R. R. 1, Box 26
Miller, Mrs. Donald C.....P. O. Box 297
Misch, Mrs. William A.....R. R. 4, Box 58

### Crown Point

Gutierrez, Mrs. P. E.....729 Williams Dr.
Horst, Mrs. William.....468 Lake St.

### East Chicago

Campagna, Mrs. E. A.....4320 Ivy St.
Ernst, Mrs. H. C.....4219 Baring Ave.
Gustaitis, Mrs. John W.....4318 Parrish Ave.
Niblick, Mrs. James S.....4115 Fir St.
Romero, Mrs. Plinio.....2103 Franklin St.
Serna, Mrs. Jesus A.....4316 Parrish Ave.
Shapiro, Mrs. Joseph.....4214 Parrish Ave.

### East Gary

Markle, Mrs. Joseph G.....3143 Ripley
Penn, Mrs. R. A.....2334 Vigo St.

### Gary

Almquist, Mrs. C. O.....550 Lincoln St.
Bills, Mrs. R. J.....410 Roosevelt St.
Bills, Mrs. Robert N.....534 Lincoln St.
Brady, Mrs. Samuel J.....451 Garfield St.
Brincko, Mrs. John.....3537 Harrison St.
Carbone, Mrs. Joseph A.....526 Johnson St.
Dierolf, Mrs. Edward.....630 N. Montgomery St.
English, Mrs. Hubert M.....575 Taft St.
Gallinatti, Mrs. J. J.....7413 Locust St.
Glover, Mrs. W. J.....3540 Tyler St.
Goldberg, Mrs. Harold B.....825 W. 35th Ave.
Goldstone, Mrs. Arthur.....3578 Buchanan
Goldstone, Mrs. Joseph.....339 W. 35th Ave.
Hadey, Mrs. James H.....505 Taft St.
Kaltenthaler, Mrs. Albert.....5981 Grant Pl.
Kolettis, Mrs. J. G.....6401 Chanticleer Lane
Kopcha, Mrs. Joseph E.....650 Pierce St.
Lazo, Mrs. Vicente.....707 Harrison St.
Lebioda, Mrs. Henry.....230 Morningside Ave.
Lytwakiwsky, Mrs. Anatol.....8700 Forest Ave.
Manalo, Mrs. F. S.....538 Lincoln St.
Marcus, Mrs. M. C.....8641 Lakeshore Dr.
Mather, Mrs. J. Winford.....7224 Maple Ave.
May, Mrs. R. Milton.....667 Van Buren St.
Milos, Mrs. Robert.....725 Filmore St.
Moswin, Mrs. Jack A.....701 Arthur St.
Ornelas, Mrs. Joseph P.....6339 Oakwood Lane
Pappas, Mrs. Edward T.....569 Pierce St.
Platis, Mrs. James.....4645 Pierce St.
Radigan, Mrs. Leo R.....6624 Birch St.
Robinson, Mrs. Walter K...500 N. Montgomery St.
Rubin, Mrs. Simon S.....2131 W. Fifth Ave.
Sala, Mrs. Joseph.....2333 W. 55th Ave.
Schulz, Mrs. Kurt J.....5814 Roosevelt St.
Scully, Mrs. John T.....715 Johnson St.
Shevick, Mrs. Alexander.....733 Fillmore St.
Spellman, Mrs. Frank W.....6941 Ironwood Ave.
Stimson, Mrs. Harry R.....4338 Jefferson St.
Valencia, Mrs. M. M.....7700 Hemlock
Yast, Mrs. Charles J.....740 Fillmore
Yocum, Mrs. P. S., Jr.....2200 Ranburn Dr.
Yocum, Mrs. Paul, Sr.....6999 Hemlock
Young, Mrs. George M.....4580 Washington St.
Zucker, Mrs. Edward.....7009 E. First St.

### Griffith

Carpenter, Mrs. B. F.....808 Glenwood
Lundeberg, Mrs. Ralph A.....1211 N. Harvey
Riordan, Mrs. John.....318 W. Glen Park Ave.
Siekierski, Mrs. J. M.....445 N. Broad Street

### Hammond

Allegretti, Mrs. Michael L.....6237 Forest Ave.
Barron, Mrs. Elmer A.....6635 Kansas
Beconovich, Mrs. Robert.....6540 Forest Ave.
Cotter, Mrs. Edward R. 7225 Knickerbocker Pkwy.

Egnatz, Mrs. Nicholas.....820 Highland St.
Elledge, Mrs. Ray.....6415 Forest Ave.
Fedor, Mrs. T. A.....6738 Hohman Ave.
Fischer, Mrs. Burnell.....49 Indi-Illi Park
Gevirtz, Mrs. Milton B.....7142 Hohman Ave.
Hack, Mrs. Edmund C.....7147 Olcott St.
Hickman, Mrs. A. Lee, Jr.....7412 Knickerbocker
Howard, Mrs. Wm. H.....41 Glendale Pk.
Husted, Mrs. Robert G.....7248 Forest Ave.
Jones, Mrs. E. S.....50 Kenwood St.
Koransky, Mrs. David S.....7048 Forest Ave.
Kretsch, Mrs. Russell W.....7214 Hohman Ave.
Marks, Mrs. Ora L.....7111 Olcott Ave.
Maroc, Mrs. James.....6826 Rosewood
Mason, Mrs. Richard L.....132 Rimbach Ave.
Modjeski, Mrs. Joseph R.
7327 Knickerbocker Pkwy.
Neal, Mrs. L. W.....7301 Forest Ave.
Panares, Mrs. Solomon V.....4 172nd Pl.
Peck, Mrs. Edward A.....6422 Moraine Ave.
Pilot, Mrs. Jean.....7137 Knickerbocker Pkwy.
Polite, Mrs. Nicholas L.....7320 California
Ramker, Mrs. Daniel T.....7129 Arizona Ave.
Remich, Mrs. Antone C.....6412 Moraine Ave.
Repay, Mrs. W. A.....7130 Knickerbocker Pkwy.
Rhind, Mrs. A. W.....7126 Forest Ave.
Rosevear, Mrs. Henry J.....6531 Forest Ave.
Row, Mrs. Perrie Q.....6712 Hohman Ave.
Rubright, Mrs. Robert L.....7258 Forest Ave.
Rudolph, Mrs. F. G.....6607 Forest Ave.
Santare, Mrs. Vincent J.....6508 Forest Ave.
Schlesinger, Mrs. Daniel J.....6633 Forest Ave.
Stern, Mrs. S. Lewis.....226 Oakwood
Thegze, Mrs. George A.....7435 Olcott Ave.
Trachtenberg, Mrs. Lee.....7226 Tilly Dr.
Wong, Mrs. Samuel N.....6329 Jackson

**Highland**

Bacevich, Mrs. A. J.....8737 Parkway Dr.
Dumanian, Mrs. Ara V.....8727 Parkway Dr.
Reed, Mrs. Ronald.....2145 Lincoln
Tilka, Mrs. Ed. C.....8740 Parkway Dr.
White, Mrs. G. H., Jr.....8754 Parkway Dr.

**Hobart**

Bernard, Mrs. Marvin R.....6430 Grand Blvd.
Faulkner, Mrs. Donald.....295 S. Wisconsin
Kellar, Mrs. Philip E.....1331 Lincoln St.
Krsek, Mrs. Archie.....1216 State St.
Reed, Mrs. John.....445 Kelley
Weiss, Mrs. J. T.....420 S. Wabash

**Munster**

Alt, Mrs. Edward M. Jr.....8804 Baring
Angel, Mrs. Virgil E.....8638 Baring
Arbeiter, Mrs. Herbert I.....119 Beverly Place
Arrowsmith, Mrs. James L.....8138 Forest Ave.
Benchik, Mrs. Frank A.....8326 Hawthorne Dr.
Bombar, Mrs. Leslie E.....8318 Oakwood
Boys, Mrs. F. F.....8517 Crestwood Ave.
Branco, Mrs. Arthur M.....8004 Monroe
Chael, Mrs. Tom C.....225 Belmont Place
Costello, Mrs. Albert J.....1404 Fisher
Egnatz, Mrs. Charles D.....8134 Columbia
Espino, Mrs. J. C.....8523 Forest Ave.
Fleischer, Mrs. J. C.....8345 Northcote
Gardiner, Mrs. H. Glenn.....1406 McArthur
Kenney, Mrs. Francis.....8131 Forest Ave.
Kmack, Mrs. Chester J.....1705 Wilson
Kuhn, Mrs. Arthur J.....1535 35th St.
Lanman, Mrs. John U.....1321 Elliott Dr.
Lautz, Mrs. Herbert A.....7943 Forest Ave.
Long, Mrs. Keith J.....1327 Ridgeway
Madlang, Mrs. R. M.....7750 Hohman Ave.
Marks, Mrs. Salvo P.....8320 Parkview Ave.
Marshall, Mrs. W. J.....1306 Elliott Dr.
Mason, Mrs. John C.....7939 Jackson
McLean, Mrs. James S.....1836 Ridge Rd.
Modjeski, Mrs. Raymond J.....1448 Elliott Dr.
Montes, Mrs. H.....7915 Hohman Ave.
Nierman, Mrs. Murray.....1544 Fischer
Paul, Mrs. Eudell G.....7905 Hohman Ave.
Rasch, Mrs. George C.....1519 35th St.
Rosenthal, Mrs. Carl.....8330 Schrieber Dr.
Schlesinger, Mrs. Jacob.....7648 Hohman Ave.
Shapiro, Mrs. Seymour W.....1517 Melbrook
Smith, Mrs. Jerald.....239 Fairbanks
Smitley, Mrs. Roger P.....1519 Janice Lane
Snyder, Mrs. Jerome.....1210 Park Drive
Sroka, Mrs. Stanley J.....7540 Forest Ave.
Stasick, Mrs. Murray .....8611 Baring Ave.
Stevens, Mrs. Edwin W.....8627 Beech
Westhaysen, Mrs. Peter V.....127 Beverly Pl.
Wooden, Mrs. Thomas F.....8351 Crestwood

**Whiting**

Greisen, Mrs. J. C.....1709 Stanton Ave.

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Fetrow, Mrs. Kenneth O.....9900 Central, Portage
Armalavage, Mrs. Leon J.....R. R. 4, Valparaiso

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Dimitroff, Mrs. Lambro
1021 Forest Hills, Calumet City, Ill.
Feinsot, Mrs. Irving
17 Forestdale Park, Calumet City, Ill.
Feldner, Mrs. Ronald P.
17717 Bernardine, Lansing, Ill.
Mansueto, Mrs. Mario D.
4 Forestdale, Calumet City, Ill.
Tyrrell, Mrs. Joseph J.
16041 S. Ellis, South Holland, Ill.

## LaPORTE COUNTY

**LaPorte**

Backer, Mrs. George P.....1533 Michigan Ave.
Carter, Mrs. Fred S.....208 Forest Dr.
Cartwright, Mrs. J. D.....1003 Indiana Ave.
Datzman, Mrs. Basil J.....1421 Indiana Ave.
Deren, Mrs. Matthew.....110 Lane St.
Durham, Mrs. Lowell J.....1808 Indiana Ave.
Feinn, Mrs. Harry S.....1534 Michigan Ave.
Kelsey, Mrs. Robert M., Jr.....1305 Indiana Ave.
Kepler, Mrs. Robert W.....1529 Michigan Ave.
Lansford, Mrs. Kenneth G.....205 Canterbury Dr.
Larson, Mrs. Goyt O.....Ridgefield Addition
Mead, Mrs. Frank E.....344 Grayson Rd.
Mladick, Mrs. Edward A.....314 Holton Rd.
Moore, Mrs. William G.....2203 Southwest Rd.
Moosey, Mrs. Louis.....2007 Michigan Ave
Mueller, Mrs. Edwin C.....117 Evergreen Dr.
Muhleman, Mrs. Charles E.....Greenacres
Oak, Mrs. David D.....1104 Andrew Ave.
Philbrook, Mrs. Seth S.....212 Forest Dr.
Richter, Mrs. John C.....2020 Beechwood Ct.
Sanchez, Mrs. Jose.....2424 Monroe St.
Scott, Mrs. John S.....508 Lake Shore Dr.
Sirugo, Mrs. Aldo C.....202 Forest Dr.
Smith, Mrs. John.....1533 Weller
Sprecher, Mrs. James J. J.....1308 Michigan Ave.
von Asch, Mrs. George.....2030 Michigan Ave.

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Carter, Mrs. William D.....Walkerton
Rohrer, Mrs. Bryce B.....Walkerton
Benz, Mrs. Owen F.....P. O. Box 163, Wanatah
Stark, Mrs. Wm..2821 Elbridge Way, Long Beach, Michigan City

## LAWRENCE COUNTY

**Bedford**

Allen, Mrs. L. Howard.....1318 14th St.

Austin, Mrs. Richard P.....1315 15th St.
Duncan, Mrs. Raymond E.....407 Northwood Dr.
Dusard, Mrs. Joseph C.....1107 N. St.
Edmonds, Mrs. Kendrick T.....438 Sycamore
Emery, Mrs. Charles B.....Brook Knoll
Fountaine, Mrs. Thomas J.....1620 18th St.
Hawkins, Mrs. Richard D.....Box 286
Kasting, Mrs. Gerald E.....Parkview Addition
Kerr, Mrs. Donald M.....1415 20th St.
Morrow, Mrs. Robert J.....Brook Knoll
Noe, Mrs. William R.....118 Woodhill Dr.
Reuter, Mrs. John W.....405 Northwood Dr.
Scherschel, Mrs. John P.....1713 H St.
Waldo, Mrs. Guy H., Jr.....308 Eastwood Dr.
Wohlfeld, Mrs. J. B.....1224 15th St.

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Benham, Mrs. Lawrence E.....R. R. 2, Springville

## MADISON COUNTY

Leroy, Mrs. A. G.....Alexandria

### Anderson

Aagesen, Mrs. W. J.....3 Wind Ridge Rd.
Armington, Mrs. Charles L.....823 W. Seventh St.
Armington, Mrs. John C.....206 W. 14th St.
Austin, Mrs. Charles E.....1612 Westwood Dr.
Baughn, Mrs. William L.....1517 Winding Way
Beeler, Mrs. Frank K.....20 Overlook Dr.
Bixler, Mrs. Donald P.....1611 Van Buskirk Rd.
Blassaras, Mrs. Crist A.....916 Dresser Dr.
Bowers, Mrs. Richard C.....1110 Greenway Dr.
Bridges, Mrs. Alvin L.....R. R. 2, Box 296 A
Buckles, Mrs. David L.....44 Knoll Rd.
Bush, Mrs. Edw. R.....19 Northway Ct.
Castetter, Mrs. Gregory K.....429 W. 11th St.
Conrad, Mrs. Ernest M.....2124 Meridian St.
Denny, Mrs. Melvin H.....1719 N. Madison Ave.
Doenges, Mrs. James L.....1601 Van Buskirk Rd.
Donaldson, Mrs. Frank C.....2 Wind Ridge Rd.
Drake, Mrs. James R.....2210 W. 12th St.
Drake, Mrs. John C.....920 N. Madison Ave.
Drennen, Mrs. Robert V...1230 E. Chesterfield Dr.
Dulin, Mrs. Basil B.....1120 Maryland Drive
Ellis, Mrs. Seth W.....1105 Green Way Dr.
Elsten, Mrs. Wayne A.
1333 Maryland Dr., Forest Manor
Erehart, Mrs. Archie D.....2214 W. Ninth St.
Faust, Mrs. Howard, Jr.....1321 W. Eighth St.
Ferguson, Mrs. Donald H.....3430 Redwood Rd.
Fischer, Mrs. Warren E.....1410 Van Buskirk Rd.
Gahimer, Mrs. Joseph E.....1515 Greenway Dr.
Gante, Mrs. Henry W.....2005 Nichol Ave.
Harvey, Mrs. E. C., Jr.....3617 Manor Rd.
Jarrett, Mrs. Paul.....2541 North Shore Dr.
Jones, Mrs. Albert T.....3316 Cherry Rd.
Jones, Mrs. David G.....R. R. 5, Box 187
Kelly, Mrs. Wendell C.....23 Colony Rd.
Kepner, Mrs. R. S.....909 Forest Dr.
Kiely, Mrs. John T.....1011 Raible
King, Mrs. Joseph W.....311 W. Eighth St.
Kopp, Mrs. William R.....2410 W. 12th St.
Lamey, Mrs. Paul T.....1740 W. 10th St.
Land, Mrs. Richard.....713 Winding Way
Larmore, Mrs. Joseph L.....1301 Winding Way
Litzenberger, Mrs. Sam W.....823 Forest Dr.
Long, Mrs. Paul L.....828 Dresser Dr.
Metcalf, Mrs. George B.....830 W. Eighth St.
Miethke, Mrs. Richard.....107 Edgewood Dr.
Moneyhun, Mrs. James E.....1815 Ivy Dr.
Morris, Mrs. Robert A.....410 Golf Club Rd.
Neale, Mrs. Alfred E.....725 Forest Dr.
Nesbit, Mrs. Leonard L.....60 River Forest
Owens, Mrs. T. F.....St. Rd. 9, South
Patterson, Mrs. William K.....3 South Park Dr.
Polhemus, Mrs. Warren C.....1300 W. 11th St.
Price, Mrs. Ambrose M.....3821 St. Rd. 9, North
Rosenbaum, Mrs. Lloyd E.....804 Dresser Dr.
Ross, Mrs. Guy E.....1124 N. Madison Ave.
Sharp, Mrs. William L.....725 North Shore Blvd.
Sheldon, Mrs. Suel A.....2812 Greenbriar Rd.
Stamper, Mrs. Jos. H.....619 State Road 67 West
Stamper, Mrs. Robert J.....R. R. 6, Box 78A
Starks, Mrs. William O.....1525 Winding Way
Stinson, Mrs. William M.....17 River Forest
Swan, Mrs. Richard C.....707 Forest Dr.
Taylor, Mrs. James A.....3232 Maryland Dr.
Wagoner, Mrs. John R.....3522 Hawthorne Rd.
Webb, Mrs. Harry D.....1308 Maryland Dr.
Weiss, Mrs. Louis L.....1225 N. Madison Ave.
Whitaker, Mrs. Jack D.....3235 Maryland Dr.
Wilder, Mrs. G. B.....338 W. 8th St.
Wilkinson, Mrs. Roger L.....404 Central Way
Williams, Mrs. Francis M.....1012 Park Rd.
Williams, Mrs. Robert H...715 North Shore Blvd.
Wishard, Mrs. Fred B.....2604 E. 4th St.
Woodbury, Mrs. C. R.....835 Park Road

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Bishop, Mrs. Harry A.....Frankton
Williams, Mrs. Robert D.....Markleville
Begley, Mrs. Robert W.
R. R. 2, Box 220-A, Pendleton
Heckaman, Mrs. Ed.....Box 28, Pendleton
McLaughlin, Mrs. C. B.....R. R. 2, Pendleton
Van Ness, Mrs. William.216 S. Main, Summitville

## MARION COUNTY

Ramage, Mrs. Walter F.....244 S. First St.,
Beech Grove
Link, Mrs. Goethe.....Box 84, Brooklyn
Cuthbert, Mrs. Marvin P..R. R. 2, Box 386, Carmel
Harris, Mrs. James C.....10816 Jordan Road,
R. R. 1, Box 622Q, Carmel
Hasewinkel, Mrs. Carroll W.
R. R. 2, Box 354, Carmel
Nolin, Mrs. Richard T..R. R. 2, Box 323D, Carmel
Myers, Mrs. Roy V.
7710 Beta Circle, W. Palm Beach, Fla.
Onyett, Mrs. Harold R..R. R. 3, Box 32, Greenwood

### Indianapolis

A

Albertson, Mrs. Frank P...5031 Rockville Rd. (24)
Aldrich, Mrs. Harry D.....5805 Sherman Dr. (20)
Alig, Mrs. Vincent B.....6453 Green Leaves (20)
Allen, Mrs. Robert K.....737 Sherwood Dr. (40)
Alvis, Mrs. Edmond O.....474 W. 92nd St. (60)
Anshutz, Mrs. William M..6340 Braemore Rd. (20)
Antreasian, Mrs. Berj.....5465 Mark Lane (26)
Appel, Mrs. Richard H.....122 E. 61st St. (20)
Arbogast, Mrs. John L. 3933 Washington Blvd. (5)
Armer, Mrs. Robert M...4208 Cold Spring Rd. (8)
Armstead, Mrs. John W..432 W. Hampton Dr. (8)
Asher, Mrs. Ernest O.....4640 W. 71st St. (68)
Asher, Mrs. James W.....R. R. 16, Box 355 (78)
Avery, Mrs. George O...5321 N. Kessler Blvd. (8)

B

Bachmann, Mrs. Arnold J.....1615 Oles Drive (8)
Bakemeier, Mrs. Otto H..5535 E. St. Clair St. (19)
Bakemeier, Mrs. Robert E.
1210 N. Butler Ave. (19)
Balch, Mrs. James E.....6829 Willow Rd. (20)
Ball, Mrs. Joseph E.....6612 E. Ninth St. (19)
Baptisti, Mrs. Arthur, Jr.
4401 N. Meridian St. (8)

Bastnagel, Mrs. William F.
5430 Washington Blvd. (20)
Batman, Mrs. Gordon W.
6906 N. Delaware St. (20)
Battersby, Mrs. J. Stanley..6001 Sunset Lane (8)
Bauer, Mrs. Thomas....7685 Clarendon Rd. (60)
Baumeister, Mrs. Herbert E.....4421 E. 75th (20)
Beamer, Mrs. Parker R...4620 Boulevard Pl. (8)
Beasley, Mrs. Thos. J.....715 E. 70th Place (20)
Beaver, Mrs. Howard W.
303 E. Edgewood Ave. (27)
Beck, Mrs. Evart M.....6445 N. Olney St. (20)
Becker, Mrs. Harry G...5641 Haverford Ave. (20)
Beeler, Mrs. John W.....7974 N. Illinois St. (60)
Beeler, Mrs. Raymond C.....3777 N. Meridian (5)
Belt, Mrs. James H.....8652 Emerald Lane (60)
Benedict, Mrs. Paul F.....2550 Blue Grass Dr. (8)
Bennett, Mrs. Ivan F.....R. R. 18, Box 285 (24)
Berman, Mrs. J. K.....2810 W. 38th St. (8)
Bibler, Mrs. Lester D.
4360 N. Pennsylvania St. (5)
Blackwell, Mrs. Donald S.....7318 Dean Rd. (40)
Blake, Mrs. Albert L...6471 Knyghton Rd. (20)
Blatt, Mrs. A. Ebner....5330 N. Illinois St. (8)
Boling, Mrs. Fred F..3333 Melbourne Rd. S. Dr. (8)
Boling, Mrs. Grover C., Jr.
6205 Bramshaw Rd. (20)
Bomalaski, Mrs. Donald....6491 N. Oxford (20)
Booth, Mrs. Boynton H...5735 Braewick Road (20)
Bowman, Mrs. George W.
5634 Carrollton Ave. (20)
Boyer, Mrs. Floyd A.....136 S. Wittfield St. (19)
Brady, Mrs. Thomas A., Jr.
225 Wellington Rd. (20)
Brayton, Mrs. John R.
3128 E. Fall Creek Blvd., N. Dr. (5)
Brayton, Mrs. Lee.....5540 N. Illinois St. (8)
Brickley, Mrs. Richard A.
5954 Hillside Ave., W. Dr. (20)
Brillhart, Mrs. James R.....4420 E. 75th (50)
Brodie, Mrs. Donald W.....R. R. 13, Box 397 (26)
Brooks, Mrs. Fred.....1660 Cunningham Dr. (24)
Brown, Mrs. Archie E.
4145 Melbourne Rd., W. Dr. (8)
Brown, Mrs. David E.....R. R. 16, Box 93 (78)
Brown, Mrs. DeWitt W., Jr.
4363 Cold Springs Rd. (8)
Brown, Mrs. Gordon T.....8170 Oakland Rd. (40)
Brown, Mrs. Wendell E.....3750 N. Gale St. (18)
Browning, Mrs. James S.
7961 Windcombe Blvd. (40)
Bruce, Mrs. Reginald A...5752 Grandiose Dr. (8)
Brueckmann, Mrs. F. Robert 2356 N. Kenyon (19)
Burdette, Mrs. Harold.....6310 Glencoe Dr. (20)
Butler, Mrs. Robert M...4849 N. Ritter Ave. (26)

C

Cahn, Mrs. Hugo....5535 N. Pennsylvania St. (20)
Call, Mrs. Herbert F.....710 E. 57th St. (20)
Call, Mrs. William H.....4101 Melbourne Rd. (8)
Campbell, Mrs. H. E., Jr..7650 Spring Mill Rd. (60)
Campbell, Mrs. Robert L..5726 Sherman Ave. (20)
Carter, Mrs. Oren E.....5461 Kenwood Ave. (8)
Chernish, Mrs. Stanley M...4403 Radnor Rd. (26)
Christie, Mrs. Marvin C.
3340 E. Loretta Drive (27)
Clark, Mrs. Geo. A.....620 Forest Blvd. (40)
Clark, Mrs. Lawson J.
2425 E. Kessler Blvd., E. Dr. (20)
Coggeshall, Mrs. Warren E.
6305 Bramshaw Rd. (20)
Cohn, Mrs. Frank....1120 Southview Dr. (27)
Conway, Mrs. Glenn.....2235 E. Garfield Dr. (3)
Cortese, Mrs. James V.....6302 Minlo Dr. (27)
Cortese, Mrs. Thomas A.....3525 Payne Dr. (27)
Costin, Mrs. Robert L..8028 Morningside Dr. (40)
Countryman, Mrs. Frank 5633 Central Ave. (20)
Cross, Mrs. David G.....3001 Redfern Dr. (27)
Culbertson, Mrs. Clyde G.....6060 Park Ave. (20)
Currie, Mrs. Robert W.....512 E. 57th St. (20)
Curry, Mrs. R. Louis.....7250 N. Chester (40)

D

Daley, Mrs. Edward H.
5118 East Dickson Road (26)
Dallas, Mrs. F. R.....3649 E. 71st St. (20)
Dalton, Mrs. Wm. W.....4205 Otterbein Ave. (27)
Daly, Mrs. Joseph M.....5969 Singleton Ave. (27)
Davidson, Mrs. Dale A...3025 N. Meridian St. (8)
Davis, Mrs. Bennie L.....302 W. Hampton Dr. (8)
Davis, Mrs. Sam J.....4545 Broadway (5)
Dearmin, Mrs. Robert M..6616 Spring Mill Rd. (60)
DeArmond, Mrs. Albert M.
5401 N. Delaware St. (20)
Deever, Mrs. John W.....6801 S. East St. (27)
Denny, Mrs. James W.
6633 Spring Brook, N. Dr. (19)
Dill, Mrs. Charles W.....4111 S. Sherman Dr. (27)
Dillon, Mrs. John F.....310 Pine Dr. (2)
Dolan, Mrs. Patrick A.....1925 Weslynn Dr. (8)
Donato, Mrs. Albert M...5915 Lawrence Dr. (26)
Doran, Mrs. J. Hal.....3705 N. Denny St. (18)
Douglas, Mrs. William T.....40 N. Ritter St. (19)
Dryden, Mrs. Gale E...5835 N. Tacoma Ave. (20)
Dugan, Mrs. William M.
5747 Rolling Ridge Rd. (20)
Dunkin, Mrs. Ramon S.....4107 Deborah St. (24)
Dupes, Mrs. Lowell E.....5851 White Oak Ct. (20)
Dyar, Mrs. Edwin W., Jr.....120 Arden Dr. (20)
Dyar, Mrs. Robert W.....6343 Maple Dr. (20)
Dyke, Mrs. Richard W.....542 W. 83rd (60)
Dyken, Mrs. Mark L.....6101 N. Delaware St. (20)
Dziabis, Mrs. Marvin D.....416 Golf Lane (60)

E

Eastman, Mrs. Joseph Rilus 220 W. 64th St. (8)
Eaton, Mrs. Edwin R...5750 Allisonville Rd. (20)
Eaton, Mrs. Lyman D...R. R. 19, Box 487Y (80)
Ebert, Mrs. J. Wayne....1125 Southview Dr. (27)
Egbert, Mrs. Herbert L.....419 W. 63rd St. (8)
Eicher, Mrs. Palmer O. 4401 Washington Blvd. (5)
Eldridge, Mrs. Gail E.....6377 Sunset Lane (60)
Elkins, Mrs. James P.....2045 Lick Creek Dr. (3)
Ellis, Mrs. Bert E.....3910 E. 57th St. (20)
Ellis, Mrs. Charles R.....5326 Falcon Lane (24)
Ellis, Mrs. William N.....4908 E. 46th Street (26)
Emhardt, Mrs. John T.....3305 Brill Rd. (27)
Ensminger, Mrs. Leonard A.
1321 N. Meridian St. (2)
Everly, Mrs. Ralph V.....1105 E. 58th St. (20)

F

Fausset, Mrs. C. Basil..7757 N. Meridian St. (60)
Feeney, Mrs. Martin T.....2302 E. 57th St. (20)
Ferry, Mrs. Francis A...935 E. Southern Ave. (3)
Finneran, Mrs. Joseph C.....1250 E. 80th St. (40)
Fischer, Mrs. A. Alan.....2515 Knollwood Dr. (8)
Flanders, Mrs. Robert, Jr.
7232 Sylvan Ridge Rd. (40)
Flanigan, Mrs. Meredith B. 3305 Rutledge Dr. (8)
Flora, Mrs. Joseph O.....5604 Rockville Rd. (24)
Folkening, Mrs. Norval C.....5501 Camden (27)
Forbes, Mrs. Robert S.
4110 Crooked Creek Overlook (8)
Fortuna, Mrs. Frank.....2535 E. Banta Rd. (27)
Foster, Mrs. John A.....7608 E. 34th Pl. (26)
Foster, Mrs. Lee N., Jr...3824 Ashbourne Ln. (18)
Fouts, Mrs. Paul J.....8393 N. Illinois St. (60)
Franklin, Mrs. William L.....33 E. 37th St. (5)
Franz, Mrs. Sherman G.....3714 N. Kiel Ave. (41)
Freed, Mrs. Carl A.....4334 Springwood Trail (8)
Freeman, Mrs. Leslie W...5601 E. St. Clair (26)
Freeman, Mrs. Max E...4802 Thornleigh Dr. (26)
French, Mrs. Richard N., Jr.
5407 N. Illinois St. (8)
Fry, Mrs. Robert D.....5717 Broadway (20)
Fulper, Mrs. James C.....4414 Maple Lane (26)

Funkhouser, Mrs. A. G.....215 E. 36th (5)

G

Gabovitch, Mrs. Edward R. 595 Holiday Lane (60)
Gaddy, Mrs. E. T.....4580 Lincoln Rd. (8)
Gaddy, Mrs. Nelson D.....2551 Blue Grass Ct. (8)
Galloway, Mrs. John A.....4835 N. Dearborn (5)
Gambill, Mrs. J. R.....4651 Cherry Lane (8)
Gambill, Mrs. William D...2272 Wynndale Rd. (8)
Garber, Mrs. J. Neill
7036 N. Pennsylvania St. (20)
Garceau, Mrs. George J.
5539 N. Pennsylvania St. (20)
Gardiner, Mrs. Sprague H...330 W. 62nd St. (8)
Gardner, Mrs. Austin
7701 N. Pennsylvania St. (40)
Gardner, Mrs. Buckman.....22 E. 52nd St. (20)
Garrett, Mrs. Robert A...95 Wellington Rd. (8)
Gastineau, Mrs. Frank M.
4444 Kessler Blvd., E. Dr. (20)
Geider, Mrs. Roy A.
5816 Pleasant Run Pkwy., N. Dr. (19)
Gick, Mrs. Herman H.....451 Eastern Ave. (1)
Gifford, Mrs. Fred E...5125 N. Meridian St. (8)
Gillespie, Mrs. Charles F..4530 Berkshire Rd. (18)
Gillespie, Mrs. Jacob E.....4426 Broadway (5)
Ginsberg, Mrs. S. T.....7222 Stevens Lane (60)
Goldman, Mrs. Samuel....428 Woodmere Dr. (20)
Gormley, Mrs. Joseph J.
4560 Crooked Creek Ridge Dr. (8)
Gosman, Mrs. James H.
4491 Washington Blvd. (5)
Graham, Mrs. John D.....6401 Osborn Dr. (26)
Grayson, Mrs. Ted L. 925 Forest Blvd. N. Dr. (40)
Greene, Mrs. Morgan E.
2014 Winchester Dr. (27)
Greist, Mrs. John H...4343 Washington Blvd. (5)
Griffin, Mrs. Leslie.....3203 W. 57th St. (8)
Grisell, Mrs. Ted L...5211 Brendon Ridge Rd. (26)
Grosz, Mrs. Hanus J.....4054 Sawyer St. (26)
Gruber, Mrs. Charles M., Jr.
3102 Kessler Blvd., E. Dr. (20)
Gustafson, Mrs. Gerald S.
5768 N. Pennsylvania St. (20)

H

Habegger, Mrs. E. Dale....3120 W. 51st St. (8)
Hadley, Mrs. David.5601 N. Pennsylvania St. (20)
Haggard, Mrs. Edmund B.
5914 N. Emerson Ave. (20)
Hall, Mrs. Frank M.
8633 N. Pennsylvania St. (40)
Hall, Mrs. Jack H.....5960 Braewick Rd. (26)
Hamilton, Mrs. Howard B.
3425 Green Hills Overlook (22)
Hampshire, Mrs. Donald R.
7979 Morningside Dr. (40)
Hann, Mrs. E. Carl ...5218 Laurel Hall Dr. (26)
Hanna, Mrs. Thomas A.....5009 W. 15th St. (24)
Harcourt, Mrs. Allan K.
5418 Allisonville Rd. (20)
Harcourt, Mrs. Robert S...6408 Braemore Rd. (20)
Harding, Mrs. M. Richard.5440 Channing Rd. (26)
Harger, Mrs. Robert W...46 West 52nd Street (8)
Haslinger, Mrs. Clarence J.
5236 Boulevard Pl. (8)
Hatfield, Mrs. Jack J. 5538 N. Keystone Ave. (20)
Hatfield, Mrs. Nicholas W...5851 E. 54th Pl. (26)
Hawk, Mrs. James H.....400 E. 43rd St. (5)
Haymond, Mrs. Joseph L.
2745 Crescent Hill Lane (8)
Hays, Mrs. Everett L.....2607 Manker Ave. (3)
Healey, Mrs. Robert J.
5559 Washington Blvd. (20)
Hedrick, Mrs. Philip W.
9232 N. Delaware St. (40)
Heimburger, Mrs. Robert F. 4462 Central Ave. (5)
Helmer, Mrs. O. M.....5015 N. Illinois St. (8)
Hendricks, Mrs. Fred A. 5867 N. New Jersey (20)
Henry, Mrs. R. S.....4367 Lincoln Rd. (8)
Hepburn, Mrs. Charles K.
7570 Morningside Dr. (40)
Heubi, Mrs. John E.....6904 N. Park Ave. (20)
Hickman, Mrs. Jack W.
3736 Spring Hollow Rd. (8)
Hickman, Mrs. Walter F. 5959 Gladden Dr. (20)
Hill, Mrs. James K.....2507 Bluffwood Dr. (8)
Hilldrup, Mrs. Don G.....5672 N. Illinois St. (8)
Hogan, Mrs. Michael A.
1807 W. 72nd Pl. (50)
Holland, Mrs. Wm.....4345 N. College Ave. (5)
Holman, Mrs. Jerome E., Jr.
5930 Central Ave. (20)
Holman, Mrs. Jerome E., Sr.
4503 E. Kessler Blvd., E. Dr. (20)
Holmes, Mrs. George H., Jr.
7421 E. Frederick Dr. (60)
Hood, Mrs. Ainslee A...1810 Rosedale Drive (27)
Howell, Mrs. Joseph D.....4514 E. 79th St. (50)
Hoyt, Mrs. Millard L...5725 Hunterglen Rd. (26)
Hubbard, Mrs. Jesse D.....4330 Black Oak Dr. (8)
Hudson, Mrs. Foster J.....3865 Cheviot Pl. (18)
Hull, Mrs. Ronald H.....6252 Bramshaw Rd. (20)
Hummons, Mrs. Francis D. 4045 Clarendon Rd. (8)
Hurteau, Mrs. William W...201 West 75th St. (60)
Huse, Mrs. Wm. Murray
5131 N. Pennsylvania St. (5)

I-J

Irwin, Mrs. Glenn W., Jr. 8025 N. Illinois St. (60)
Iske, Mrs. Paul G.....5207 Central (20)
Jaquith, Mrs. Orville S...261 Blue Ridge Rd. (8)
Jewett, Mrs. Joe H.....5803 Sherman Ave. (20)
Jinks, Mrs. Clifford H.....1831 E. 61st St. (20)
Johnson, Mrs. Earl H...550 W. 77th St. N. Dr. (60)
Johnson, Mrs. Thomas W.....351 W. 63rd St. (60)
Jones, Mrs. David E...5433 Hawthorne Dr. (26)
Jones, Mrs. George.. 8933 Southeastern Ave. (19)
Joseph, Mrs. Rex M.....620 Hickory Lane (27)
Jowitt, Mrs. Richard H.
5390 Brendonridge Rd. (26)
Judd, Mrs. Russell L.....5327 Mark Lane (26)
Judson, Mrs. Walter E.....844 Fleetwood Dr. (8)

K

Kaiser, Mrs. James L.....333 E. Beverly Dr. (5)
Kammen, Mrs. Leo.....7030 Central Ave. (20)
Karsell, Mrs. Wm. A...5310 Staughton Dr. (26)
Katterjohn, Mrs. James C.
9035 Pickwick Dr. (60)
Keenan, Mrs. Reid L...3702 N. Delaware St. (5)
Keever, Mrs. Charles H., Sr.
9016 Keever Dr., R. R. 18, Box 289 B (24)
Kendrick, Mrs. Wm. M..8350 N. Pennsylvania (40)
Kennedy, Mrs. Hunter F....5790 E. Michigan (19)
Kennedy, Mrs. Joseph T.
5316 Brendonridge Rd. (26)
Kenney, Mrs. David B.....6711 E. Tenth St. (19)
Kenzler, Mrs. Jack I.....6040 E. 65th Place (20)
Kerr, Mrs. Harry R...5774 Washington Blvd. (20)
King, Mrs. Harold K...4606 Washington Blvd. (5)
Kingsbury, Mrs. John K.
5776 E. Michigan St. (19)
Kirtley, Mrs. William R...7447 N. Park Ave. (20)
Kissel, Mrs. Wesley A...3721 Briarwood Dr. (20)
Klain, Mrs. Benjamin V.
8419 N. Pennsylvania St. (20)
Kneidel, Mrs. J. H.....918 E. 57th St. (20)
Knowles, Mrs. Charles Y...5420 Channing Rd. (26)
Kohlstaedt, Mrs. Kenneth G...645 E. 80th St. (40)
Kooiker, Mrs. John E.....3540 Watson Road (5)
Koons, Mrs. Karl M.
5767 N. Pennsylvania St. (20)
Kornafel, Mrs. Laddie H...6201 College Ave. (20)
Kuntz, Mrs. Herman W.
2065 Lick Creek Drive (3)

L

LaDine, Mrs. Clarence B...5417 N. Meridian (8)
Lamb, Mrs. Emmett B...1180 Golden Hill Dr. (8)
Lamb, Mrs. Russell W....4636 N. Capitol Ave. (8)
Lamber, Mrs. Chet
3965 N. Meridian, Apt. 4D (8)
Lang, Mrs. Jay W.....54 S. Johnson Ave. (19)
Lasich, Mrs. Anthony R....5320 Channing Rd. (26)
Leasure, Mrs. J. Kent
3060 N. Meridian #401 (8)
Leff, Mrs. A. H.....160 Penn Ridge Dr. (40)
Leffler, Mrs. William T.....250 E. 70th St. (20)
LeMaster, Mrs. Theodore R.
2621 McLeay Dr. (20)
Levi, Mrs. Leon....6902 N. Pennsylvania St. (20)
Lewis, Mrs. Paul S.....6380 W. Ohio St. (24)
Lewis, Mrs. Robert J...5800 Lawrence Dr. (26)
Ley, Mrs. Glen.....3556 Guilford (5)
Lichtenberg, Mrs. Melvin
5677 N. Meridian St. (8)
Lindenborg, Mrs. Paul G.....4304 E. 46th St. (26)
Lingeman, Mrs. Raleigh E.
4235 N. Pennsylvania (8)
Lochry, Mrs. Ralph L.
5801 N. Olney St., Apt. 9 (20)
Loehr, Mrs. Wm. M...1426 E. Kessler Blvd. (20)
Lord, Mrs. Glenn C.....7437 Holliday Dr. W. (60)
Loughlin, Mrs. Leo 5616 N. Pennsylvania St. (20)
Love, Mrs. George N. 5331 Washington Blvd. (20)
Lukemeyer, Mrs. George T.
3845 N. Campbell Ave. (26)
Lunsford, Mrs. Thomas E.....215 E. 71st St. (20)
Lurie, Mrs. Paul R.....5 W. 79th St. (60)
Luros, Mrs. J. Theodore....156 Fairway Dr. (60)
Lybrook, Mrs. William B.
4585 Kessler Blvd., E. Dr. (20)

M

McAlpine, Mrs. Richard J...8102 Oak Hill Dr. (50)
McAree, Mrs. Francis E.....5444 Mark Lane (26)
McCallum, Mrs. Donald C.....6534 Hythe Rd. (20)
McCartney, Mrs. Donald H. 410 East 56th St. (20)
McClain, Mrs. Edwin S.
416 W. 77th St. (60)
McCormick, Mrs. Charles O., Jr.
4240 Glencairn Lane (18)
McGrath, Mrs. Michael F.
6183 Washington Blvd. (20)
McIntyre, Mrs. James M.
7360 Hazelwood Ave. (60)
McLaren, Mrs. Daniel E.....4479 Barnor Dr. (26)
Mackey, Mrs. John E.....940 W. 58th St. (8)
Madden, Mrs. Robert J.....1420 Audubon Rd. (19)
Malcolm, Mrs. R. L., Jr..R. R. 17, Box 580B (23)
Manalan, Mrs. Maurice M.
7807 Meadowbrook Dr. (40)
Manders, Mrs. Karl L.
4925 Buttonwood Crescent (8)
Manion, Mrs. Marlow W.
5132 N. New Jersey St. (5)
Manning, Mrs. Randolph
5302 N. Delaware St. (20)
Manzie, Mrs. Michael.....2687 W. 44th St. (8)
Markstone, Mrs. David H...6002 Cadillac Dr. (24)
Marshall, Mrs. Albert L., Jr.
7802 Allisonville Rd. (20)
Marshall, Mrs. Cavins R....4103 N. Illinois St. (8)
Martin, Mrs. Loren H.
5338 Washington Blvd. (20)
Martz, Mrs. Carl D.....7926 Hawthorn Ct. (26)
Masters, Mrs. John M.....34 E. 46th St. (5)
Masters, Mrs. Robert J.....330 W. 106th St. (90)
Matthew, Mrs. W. Burleigh
800 W. Kessler Blvd. (8)
Matthews, Mrs. B. J.....966 North Graham (19)
Matthews, Mrs. William M.
1122 N. Bolton Ave. (19)
Maxam, Mrs. Beverly T. 6220 Sunset Lane (24)
Megenhardt, Mrs. Dennis S.
3038 E. Fall Creek Pkwy. N. Dr. (5)
Meiks, Mrs. Lyman T.
4203 N. Pennsylvania St. (5)
Melin, Mrs. John R.....2628 Knollwood Dr. (8)
Merrell, Mrs. Paul.....5367 Kenwood (8)
Mertz, Mrs. John H. O.....5950 Central Ave. (20)
Michael, Mrs. Isaac E.....5208 Roland Dr. (8)
Middleton, Mrs. H. N...3828 Rookwood Ave. (8)
Miller, Mrs. Jerry R...7237 Sylvan Ridge Rd. (40)
Miller, Mrs. Lee H.....2011 Mitthoeffer Rd. (19)
Miller, Mrs. Roscoe E.....R. R. #17, Box 503 (23)
Mitchell, Mrs. Earl N.
1222 N. Irvington Ave. (19)
Moak, Mrs. Glenn D.....2155 Weslynn Dr. (8)
Moore, Mrs. Donald F. 1315 West 10th Street (7)
Moore, Mrs. Harold T...5802 Allisonville Rd. (20)
Moriarty, Mrs. John.....6130 Smock Dr. (27)
Morrison, Mrs. Lewis E., II
5751 Wildwood Ave. (20)
Morton, Mrs. Joseph L.....3272 W. 42nd St. (8)
Morton, Mrs. Walter P.
3434 E. Fall Creek Blvd., N. Dr. (5)
Moss, Mrs. H. C.....4802 Washington Blvd. (5)
Mothersill, Mrs. Mark H.....3650 College Ave. (5)
Mouser, Mrs. Robert W.
5555 N. Meridian St. (8)
Muller, Mrs. Lullus P.
5675 Washington Blvd. (20)

N

Nagan, Mrs. Robert F.....3902 Devon Dr. (18)
Nay, Mrs. Richard M.....5525 N. Meridian (8)
Need, Mrs. Louis T.....3627 Bluff Rd. (27)
Nester, Miss Lena Laura
5324 N. Pennsylvania St. (20)
Nie, Mrs. Louis W.....4305 Central Ave. (5)
Nohl, Mrs. John M.....5410 Eastridge Dr. (19)
Nolting, Mrs. Henry F...155 W. Hampton Dr. (8)
Norris, Mrs. Max S.....540 E. 36th St. (5)
Nourse, Mrs. Myron H.
8064 Morningside Dr. (20)
Nugent, Mrs. Edwin J...6840 N. Delaware St. (20)
Nurnberger, Mrs. John I.
5215 Washington Blvd. (20)

O

O'Brian, Mrs. Earl J.
4525 Crooked Creek Ridge Rd. (8)
Ochsner, Mrs. Harold C.
4565 Cold Spring Rd. (8)
Offutt, Mrs. Andrew C. 750 N. Campbell Ave. (19)
Olvey, Mrs. Ottis N.....5428 Central Ave. (20)
Otten, Mrs. Claude F..5222 Washington Blvd. (20)
Overley, Mrs. Toner M., Jr...3501 Watson Rd. (5)
Owen, Mrs. John E.....4429 N. Illinois St. (8)
Owens, Mrs. Tracy C.....2823 N. Meridian St. (8)

P

Palmer, Mrs. Harley P.....6611 Hythe Rd. (20)
Palmer, Mrs. Robert W.....2515 Willcrest Dr. (8)
Parr, Mrs. Robert L.....4407 Dickson Rd. (20)
Paulissen, Mrs. George T.....741 Markwood (27)
Paynter, Mrs. Morris B.....115 Roberts Rd. (27)
Peck, Mrs. Franklin B., Jr.
8181 Lincoln Blvd. (20)
Peirce, Mrs. James D.
5027 Washington Blvd. (20)
Permer, Mrs. Erwin.....5590 Grandview Dr. (8)
Peters, Mrs. Robert J. D.
3203 E. Michigan St. (1)
Petranoff, Mrs. Theodore V.
2814 Questend—S. Dr. (22)
Pfaff, Mrs. O. G.....4605 N. Meridian St. (8)

Pickett, Mrs. Robert D...4713 Millersville Rd. (26)
Pierce, Mrs. Emmett....1034 N. Bolton Ave. (19)
Pierce, Mrs. Raymond O., Jr..1521 W. 25th St. (8)
Pilcher, Mrs. Jack E.....4601 Graceland Ave. (8)
Pontius, Mrs. Edwin E.
6221 Avalon Lane, E. Dr. (20)
Popplewell, Mrs. Arvine G.
141 E. Southport Rd. (27)
Powell, Mrs. Richard C....6935 Munsee Lane (60)
Price, Mrs. Francis W.
550 East Edgewood Ave. (27)
Price, Mrs. Walter S..8430 Washington Blvd. (40)
Pryor, Mrs. Richard C...6134 Carrollton Ave. (20)

**R**

Rabb, Mrs. Frank M.....4619 Dickson Rd. (26)
Raber, Mrs. Robert M.....265 Williams Ct. (20)
Rader, Mrs. George S.....3778 E. 62nd St. (20)
Rafalski, Mrs. Thomas A.
3135 Shady Grove Court (22)
Ragan, Mrs. William D...2157 Wilshire Road (8)
Ramsey, Mrs. Frank B.....1401 W. 52nd St. (8)
Rapp, Mrs. George F.....2644 Falcon Dr. (24)
Rawls, Mrs. George H.....4226 N. Illinois St. (8)
Reed, Miss Ann.....4131 N. Meridian (8)
Reed, Mrs. Philip B.....4131 N. Meridian St. (8)
Rees, Mrs. Russel C.
5917 E. 12th St., Apt. 3A (19)
Reid, Mrs. Charles A.....6506 Madison Ave. (27)
Reitz, Mrs. Lawrence A.....5250 Roland Dr. (8)
Rice, Mrs. Raymond D.
5241 Washington Blvd. (20)
Rice, Mrs. Raymond M.
7799 E. Holliday Drive (20)
Rice, Mrs. Ronald B.....3625 E. 42nd St. (5)
Rich, Mrs. Richard.....5236 Hedgerow Dr. (26)
Robb, Mrs. John A...5151 N. Pennsylvania St. (5)
Rochlin, Mrs. I.....212 E. 71st St. (20)
Roesch, Mrs. Ryland.....5444 N. Illinois St. (8)
Rogers, Mrs. Donald L.
2618 Bluffwood Dr., W. (8)
Roll, Mrs. John W.....6340 Bramshaw (26)
Roller, Mrs. Charles W.....2301 Garfield Dr. (3)
Romberger, Mrs. Floyd T., Jr..10 W. 64th St. (20)
Rosenak, Mrs. Bernard D.
5254 N. Delaware St. (20)
Ross, Mrs. Alexander T. 6050 Knyghton Rd. (20)
Ruddell, Mrs. Karl R...2626 N. Meridian St. (8)
Ruddell, Mrs. Keith R..1201 Golden Hill Drive (8)
Rudesill, Mrs. Robert L. 5311 N. Pennsylvania (20)
Russell, Mrs. John R.....3864 Ruckle St. (5)
Rupel, Mrs. Ernest.....5735 N. Meridian (8)
Rust, Mrs. Roland B., Jr...6640 Sunny Lane (20)
Ruth, Mrs. Martin L.....7 N. Colorado Dr. (1)
Ryan, Mrs. C. David.....3524 Welch Dr. (24)
Ryan, Mrs. Glen V.
3168 E. Fall Creek Pkwy., N. Dr. (5)

**S**

Sage, Mrs. Russell A...7531 Morningside Dr. (40)
Salb, Mrs. Max C.....6741 Allisonville Rd. (44)
Sanders, Mrs. Fred.....4575 Ayrshire Dr. (8)
Schermer, Mrs. Kenneth L.
5845 N. Sherman Dr. (20)
Schlaegel, Mrs. T. F.....4536 Dickson Rd. (26)
Schlegel, Mrs. Donald M.....4042 Cranbrook (40)
Schmalhausen, Mrs. A. W.
6227 Hillcrest Lane (20)
Schmidt, Mrs. Loren F. 5880 Carrollton Ave. (20)
Schneider, Mrs. Carl J.....340 N. Kenyon (19)
Schneider, Mrs. Paul A.....4140 N. Graham (26)
Schnute, Mrs. Richard 5460 Broadmoor Plaza (8)
Schuchman, Mrs. Gabriel..5944 Central Ave. (20)
Schuster, Mrs. Dwight.4503 Washington Blvd. (5)
Scofield, Mrs. John B.....9014 Pickwick (60)
Scott, Mrs. Jasper P.....5840 Winthrop Ave. (20)
Scott, Mrs. John R.....7966 N. Illinois St. (20)
Scott, Mrs. Robert P.
5715 N. Pennsylvania St. (20)
Seaman, Mrs. Charles F. 5353 Channing Rd. (20)
Searight, Mrs. John L...5830 University Ave. (19)
Sedam, Mrs. Herbert L. 4819 Millersville Rd. (26)
Segar, Mrs. William E.....4855 Victoria Rd. (8)
Sellmer, Mrs. George.....8760 Driftwood (40)
Sexson, Mrs. Hiram T...5455 N. Meridian St. (8)
Shafer, Mrs. Marion R. 6290 Allisonville Rd. (20)
Shapiro, Mrs. Burton J. 525 Woodmere Dr. (20)
Shelley, Mrs. R. J.....5810 E. 46th St. (26)
Shipley, Mrs. Edward C.....3601 Marrison Pl. (5)
Shullenberger, Mrs. Wendell A.
4535 Central Ave. (5)
Shumacker, Mrs. Harris B., Jr.
6834 N. Pennsylvania St. (20)
Sicks, Mrs. Okla W.....607 E. 82nd (40)
Siderys, Mrs. Harry
5102 N. Pennsylvania St. (20)
Siersdorfer, Mrs. T. N...5559 W. Morris St. (41)
Sigmond, Mrs. Harvey..3245 N. Pennsylvania (5)
Silver, Mrs. Richard A...1114 S. Frederick Dr. (8)
Sims, Mrs. J. Lawrence....3723 N. Gale St. (18)
Sluss, Mrs. David.....3657 Washington Blvd. (5)
Smith, Mrs. E. Rogers.....160 W. 47th St. (8)
Smith, Mrs. Roy Lee..1427 West Stop 11 Rd. (27)
Solomon, Mrs. Reuben A.
5330 N. Pennsylvania (20)
Soper, Mrs. Hunter A.....R. R. 18, Box 285C
Sovine, Mrs. Joe W.....8182 N. Illinois St. (20)
Spahr, Mrs. John F., Jr.
3014 Green Hills Lane, N. Dr. (22)
Sparks, Mrs. Alan L.
5466 N. Pennsylvania St. (20)
Spears, Mrs. John M.....6910 Shelby (27)
Speckman, Mrs. Glenn H.....5242 Park Ave. (20)
Sputh, Mrs. Carl B., Jr.
5671 Rolling Ridge Rd. (20)
Stansbury, Mrs. Wm. E.....5610 E. 16th St. (18)
Stayton, Mrs. Chester A., Sr...6931 Central (20)
Stayton, Mrs. Chester A., Jr.
7065 Central Ave. (20)
Stephens, Mrs. Donald E.....5555 Broadway (20)
Stoelting, Mrs. V. K.....4706 Laurel Circle (26)
Stone, Mrs. Alvin T.....6295 N. Tuxedo (20)
Storey, Mrs. D. Edmund
808 Forest Blvd., N. Dr. (20)
Storms, Mrs. Roy B.....5041 Central Ave. (5)
Strang, Mrs. Wm. C.....7760 Cree Trail (50)
Streeter, Mrs. Ralph T....5265 N. Meridian St. (8)
Stucky, Mrs. Elsworth K.
4528 N. Meridian St. (8)
Stump, Mrs. Loyd K.....6375 Brixton Lane (20)
Suelzer, Mrs. John.....4041 Milbourne St. (8)
Strickland, Mrs. James W.
6212 Northern Lane (20)
Suess, Mrs. Robert E.....7133 Twin Oaks Dr.
Sullivan, Mrs. James J.....3458 Welch Dr. (24)
Summerlin, Mrs. Jack D.
6375 Avalon Lane, E. Dr. (20)
Sutton, Mrs. William E.....5807 Brockton Dr. (20)
Swan, Mrs. John R.....320 Arden Dr. (20)

T

Talbott, Mrs. Dan E.....6470 N. Michigan Rd. (8)
Tanner, Mrs. Henry S.
4461 N. Pennsylvania St. (5)
Taube, Mrs. Jack I...4353 N. Pennsylvania St. (5)
Taylor, Mrs. Clifford C.
3720 Briarwood Dr., E. (20)
Taylor, Mrs. Frederic W.....40 E. 43rd St. (5)
Teague, Mrs. Frank W.....555 W. Pine Dr. (60)
Tether, Mrs. J. Edward.....4839 E. 56th St. (20)
Tharpe, Mrs. Ray G.....6161 Sunset Lane (8)
Thatcher, Mrs. Hugh K., Jr...408 E. 45th St. (5)
Thoman, Mrs. Rex L.....4969 W. 11th St. (24)
Thomas, Mrs. Charles R.
7029 Wayland Dr., R. R. 5, Box 456A (39)
Thomas, Mrs. E. P.....6235 Grandview Dr. (60)
Thomas, Mrs. Fred A.....5827 Broadway (20)
Thomas, Mrs. Lowell I.....28 W. Hampton Dr. (8)

Thomas, Mrs. Morris E.
6215 Spring Mill Rd. (20)
Thompson, Mrs. John V.....7899 Ridge Rd. (20)
Thompson, Mrs. Paul D.
5939 Hillside Ave., E. Dr. (20)
Thompson, Mrs. Wayne..6365 Knyghton Rd. (20)
Throop, Mrs. Frank B.....57 E. 38th St. (5)
Thurston, Mrs. A. L.....4078 Central Ave. (5)
Tinsley, Mrs. Walter B., Sr. 5638 Broadway (20)
Tinsley, Mrs. Walter B., Jr.
4505 Melbourne Rd. (8)
Tischer, Mrs. E. Paul.....5318 E. 72nd St. (50)
Tondra, Mrs. John M.....4511 Broadway (5)
Torrella, Mrs. Jose A.....5721 W. 18th St. (24)
Trusler, Mrs. Harold M.
6150 N. Meridian St. (20)
Trusler, Mrs. H. Marshall...4360 Swanson Dr. (8)
Tuchman, Mrs. Joseph H.
8515 Springview Dr. (60)
Tucker, Mrs. Warren S.
5338 N. Pennsylvania St. (20)
Tyler, Mrs. Edward.....5693 N. Meridian St. (8)
Tyner, Mrs. Harlan H.....3663 N. Delaware (5)

U-V

Ullom, Mrs. Ralph.....520 Wayside Dr. (60)
Van Denbark, Mrs. Howard..3268 Patton Dr. (24)
Vandivier, Mrs. Robert M.
3715 N. Meridian St. #1 (8)
Van Meter, Mrs. C. Powell
4102 Marrison Place (18)
Van Nuys, Mrs. J. D....2120 E. Kessler Blvd. (20)
Van Tassel, Mrs. C. J., Jr.
5832 Washington Blvd. N. (20)
Vollrath, Mrs. Victor J.
7980 N. Pennsylvania St. (20)
Von Der Haar, Mrs. Gerard
1109 N. Mitchner St. (19)
Vore, Mrs. Robert E.....3710 Cheviot Place (5)

W

Wainscott, Mrs. Clinton S.
5332 Channing Road (26)
Waldo, Mrs. J. Thayer.....420 W. 64th St. (8)
Walther, Mrs. Joseph E.
4266 N. Pennsylvania St. (5)
Walton, Mrs. William M.
8007 N. Illinois St. (60)
Warneke, Mrs. Charles.....2533 Ryan Dr. (20)
Warriner, Mrs. James B...990 N. Bolton Ave. (19)
Warvel, Mrs. John H.
4360 Kessler Blvd., N. Dr. (8)
Weiss, Mrs. Jason.....2790 W. 38th (8)
West, Mrs. Joseph L.....2110 W. 38th St. (8)
Westfall, Mrs. B. Kemper, Jr.
4001 N. Meridian St. (8)
Wheeler, Mrs. David E.
5441 Brendonridge Rd. (26)
White, Mrs. Donald J..7218 Sylvan Ridge Rd. (40)
White, Mrs. Douglas H., Jr.
7405 Frederick Dr. East (60)
White, Mrs. J. Philip.....6180 Carvel Ave. (20)
White, Mrs. John B.....5850 Highfall Rd. (26)
Wilkens, Mrs. Irvin W.
4820 E. Pleasant Run Pkwy., N. Dr. (1)
Williams, Mrs. Charles D...160 E. 71st St. (20)
Williams, Mrs. Clifford L.
3000 W. Washington St. (22)
Williams, Mrs. Howard S., Jr.
3824 N. Delaware St. (5)
Williams, Mrs. Hugh L...6231 Knyghton Rd. (20)
Wirey, Mrs. Harold R...2949 E. Hanna Ave. (27)
Wise, Mrs. William R.....1908 Orlando (8)
Wishard, Mrs. William N., Jr.
5720 N. Pennsylvania St. (20)
Woerner, Mrs. Thos. E..7981 Dartmouth Rd. (60)
Wolfram, Mrs. Don J.
5716 N. Pennsylvania St. (20)
Wood, Mrs. Donald E...6467 W. Holliday Dr. (20)
Woolling, Mrs. Kenneth R..5751 Central Ave. (20)
Worley, Mrs. R. H.....4626 Cavendish Rd. (20)
Wrege, Mrs. Malcolm..5411 Shorewood Dr. (20)
Wunsch, Mrs. Charles.....5723 N. Delaware(20)
Wyttenbach, Mrs. John E...5509 Kenwood Ave. (8)

Y-Z

Yacko, Mrs. Michael L.
5341 N. Channing Rd. (26)
Yingling, Mrs. Robert J..5322 Hedgerow Dr. (26)
Young, Mrs. James W.....440 E. 71st St. (20)
Young, Mrs. John M.
4535 Marcy Lane, No. 261 (5)
Young, Mrs. John T.....3030 Rex Dr. (22)
Zell, Mrs. Evertson H...4747 Millersville Rd. (26)
Zerfas, Mrs. Charles P. A.....R. 1, Box 220 (27)

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Stephens, Mrs. K. H.
Morrison Rd., R. R. 3, Nashville
Harvey, Mrs. Verne K..R. R. 2, Box 354, Zionsville
Kalsbeck, Mrs. John E...R. R. 2, Box 168, Zionsville
Pennington, Mrs. Walter E.
Indiana Baptist Home, R. R. 1, Zionsville

## MARSHALL COUNTY

Hampton, Mrs. James N.....R. R. 2, Argos
Graham, Mrs. Hazel.....Bourbon
Kemp, Mrs. William....1006 N. Main St., Bourbon
Bowen, Mrs. Otis R...304 N. Center St., Bremen
Burket, Mrs. Cecil R.....121 E. Grant St., Bremen
Stine, Mrs. Marshall.420 Shumaker Dr., Bremen
Hippensteel, Mrs. Russell R.
936 South Shore Rd., Culver
Howard, Mrs. Joseph.....212 Cass St., Culver

### Plymouth

Coursey, Mrs. James.....R. R. 2, Box 282A
France, Mrs. Lloyd C.....R. R. 2, Goshen Rd.
Guild, Mrs. Kent.....800 N. Center St.
Peterson, Mrs. Ronald.....R. R. 3
Reed, Mrs. Robert G.....235 Hogarth
Reno, Mrs. Edward.....700 Ferndale
Rimel, Mrs. James F.....909 Bayless
Robertson, Mrs. James S.....1081 Highland Ct.

## MIAMI COUNTY

Shrock, Mrs. E. E.....Amboy
Crates, Mrs. Gordon.....Chili
Line, Mrs. Homer.....Chili
Sixbey, Mrs. Maurice.....Box 68, Chili
Rendel, Mrs. H. E.....Mexico

### Peru

Barnett, Mrs. Helen.....109 W. Seventh St.
Guthrie, Mrs. James U.....331 W. Third St.
Herd, Mrs. Cloyn R.....16 Farview
Hill, Mrs. Lloyd L.....520 Oak St.
Johnson, Mrs. Owen B.....106 W. Sixth St.
Snyder, Mrs. Parker W.....159 W. Sixth St.
Yarling, Mrs. Francis.....117 E. Fifth St.

## MONTGOMERY COUNTY

### Crawfordsville

Baird, Mrs. Keith.....811 W. Main St.
Burks, Mrs. Jess E.....512 W. Wabash Ave.
Cooksey, Mrs. Thomas L.....205 Marshall
Daugherty, Mrs. Fred N.....415 W. Main St.
Eggers, Mrs. Richard R.....203 S. West St.
Haller, Mrs. Thomas C.....38 Delmar Dr.
Humphreys, Mrs. John W.....1309 Durham Dr.

Kinnaman, Mrs. Howard.....R. R. 5
Kirtley, Mrs. James M.....615 Thornwood Rd.
Lingeman, Mrs. Byron N.....203 Wallace Ave.
Ludwig, Mrs. Paul E.....Country Club Rd.
Millis, Mrs. Samuel C.....201 Wallace Ave.
Peacock, Mrs. Norman F.....111 Wallace Ave.
Pierson, Mrs. Robert H.....305 E. Main St.
Richards, Mrs. Edgar E.....Danville Rd., R. R.
Shannon, Mrs. Wesley E.....6 Locust Hill Dr.
Sharp, Mrs. John L.....1113 Durham Dr.
Viray, Mrs. V. G.....809 North Dr.
Wallace, Mrs. Hawthorne C...107 W. Jefferson St.

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Otten, Mrs. Ralph E.....Darlington
Smith, Mrs. Byron J.....Kingman
Blix, Mrs. Fred.....Ladoga
Holden, Mrs. Gary R.....New Market
Kindell, Mrs. Hurschell D.....New Richmond
Rusk, Mrs. Hubert M.....Box 36, Wallace
Thompson, Mrs. Claude N.....Waynetown
Parker, Mrs. Carl B.....Wingate

## MORGAN COUNTY

### Martinsville

Brubeck, Mrs. Robert.....R. R. 6, Box 419C
Eisenberg, Mrs. David....Box 310, Sunnyside Dr.
Gray, Mrs. Leon.....589 Valley Drive N.
Miller, Mrs. Ray D.....290 E. Washington St.
Miller, Mrs. Robert J.....R. R. 3, Box 214A
Pitkin, Mrs. McKendree C...440 E. Washington St.
Reese, Mrs. Jay S.....R. R. 4, Box 21A
Van Wienan, Mrs. John.....439 N. Jefferson
Willan, Mrs. Horace R.....109 S. Jefferson
Winter, Mrs. William.....415 N. Jefferson

### Mooresville

Bivin, Mrs. James H.....N. Indiana Rd.
Comer, Mrs. Charles W.....R. R. 2
Comer, Mrs. Kenneth E.....R. R. 2
Kourany, Mrs. Edgar.....220 Saint Clair, No. 6
Kourany, Mrs. Oscar.....220 Saint Clair, No. 3
Van Bokkelen, Mrs. Robert W...124 S. Indiana St.

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Murphy, Mrs. M. G.....Box 167, Morgantown
Wilson, Mrs. Oliver R.
Box 65, R. R. 3, Morgantown

## NEWTON COUNTY

Schoonveld, Mrs. Arthur.....Brook
Parker, Mrs. John.....Goodland
Kresler, Mrs. L. E.....301 N. Sixth St., Kentland
Yegerlehner, Mrs. R. S.....146 W. Graham St., Kentland
Guzman, Mrs. Marc.....Morocco

## NOBLE-LaGRANGE COUNTIES

Bowman, Mrs. Charles M. 202 E. Main St. Albion
Nash, Mrs. Justin R.....202 N. Orange, Albion
Taylor, Mrs. Millard R.....Howe
Yunker, Mrs. Philip.....Box 188, Howe
Gutstein, Mrs. Richard R.
120 Diamond, Kendallville
Williams, Mrs. H. O.
735 Mitchell St., Kendallville
Benedict, Mrs. Charles D.
R. R. 1, Box 14, LaGrange
Studebaker, Mrs. Lloyd R.
325 W. Spring, LaGrange
Hooker, Mrs. Donald J...406 S. Main St., Ligonier
Stone, Mrs. Robert C.....501 S. Main St., Ligonier
Stultz, Mrs. Quentin F...3 Hawthorn Dr., Ligonier

## ORANGE COUNTY

Hagan, Mrs. Marion L.....Main St., French Lick
Kesseric, Mrs. Nick E.....French Lick
Sugarman, Mrs. Benjamin E.
417 Walnut St., French Lick
Clark, Mrs. Ivan A.....N. Gospel, Paoli
Spears, Mrs. John K.....312 N. Gospel St., Paoli

## OWEN-MONROE COUNTIES

### Bloomington

Austin, Mrs. Rayburn C.....114 S. Grant
Baxter, Mrs. Neal E.....515 Hawthorne
Booze, Mrs. James H.....Fieldcrest
Borland, Mrs. Raymond M.....R. R. 3, Box 51
Buck, Mrs. Roger L.....MelCurry Pike
Buckingham, Mrs. Richard.....705 S. Fess
Byrne, Mrs. Louis.....Cameron Ave., R. R. 3
Campbell, Mrs. Wm. T.....Meadowbrook Ave.
Cochran, Mrs. John F.....113 N. Concord Rd.
Creek, Mrs. J. A.....2303 Fritz Dr.
DeMott, Mrs. Russell.....904 S. Rose
Emery, Mrs. Charles B., Jr.....1316 S. High St.
Estes, Mrs. Ambrose.....701 Highland Ave.
Fowler, Mrs. R. Ross.....Pleasant Ridge Rd.
Geiger, Mrs. Dillon.....1704 N. Fee Lane
Hardtke, Mrs. Eldred F.....1400 Pickwick Place
Hepner, Mrs. Herman.....302 E. 7th
Hibner, Mrs. Kermit Q.....1306 Pickwick Pl.
Holland, Mrs. Philip T.....1001 S. Jordan
Holtzman, Mrs. Paul.....1203 Pickwick
Houshmand, Mrs. Cyrus.....102 N. Glenwood Dr.
Howard, Mrs. Wm. F.....126 Hampton Court
McClary, Mrs. Charles.....1924 E. Marilyn
Manifold, Mrs. Harold M.....1310 S. Nancy St.
Marchant, Mrs. Clarence.....350 S. College
Middleton, Mrs. Thomas.....210 Gilbert
Milan, Mrs. Joseph.....2207 Covenanter Dr.
Miller, Mrs. John M.....1402 Winfield Rd.
Poolitsan, Mrs. George.....1217 E. First St.
Ramsey, Mrs. Hugh.....619 E. First
Ratts, Mrs. Larry.....3315 Longwood Dr.
Rieger, Mrs. I. Taylor.....Woodcrest Dr.
Rogers, Mrs. Otto F.....804 E. 8th
Rollins, Mrs. Thomas.....815 S. Rose
Schell, Mrs. H. Richard.....1401 Maxwell Lane
Seagle, Mrs. W. Courtney.....1710 N. Walnut
Sibbitt, Mrs. Joseph W.....818 Sheridan
Smith, Mrs. Herschel S.....200 Glendora Dr.
Stangle, Mrs. Wm. J.....2305 E. Second
Taraba, Mrs. Ralph.....211 E. Martha St.
Topolgus, Mrs. James N.....1015 Atwater Ave.
Wass, Mrs. Robert.....3618 Morningside Dr.
Way, Mrs. James A.....Cascade Village Apts.
Wilson, Mrs. T. L.....Bender Road

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Mitchell, Mrs. George.....Smithville

## PARKE-VERMILLION COUNTIES

### Clinton

Evans, Mrs. F. J.....1315 S. Main St.
Gailey, Mrs. I. L.....257 Walnut St.
Herzberg, Mrs. Milton.....545 S. Fourth St.
Kercheval, Mrs. J. M.....Box 192
Somerville, Mrs. John W.....R. R. 2

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Webb, Mrs. L. C.....Dana
Britton, Mrs. W. D. Bloomingdale Rd., Montezuma

### Rockville

Beebe, Mrs. Milton O., Jr.....9 Valley Dr.
Bloomer, Mrs. Richard S.....502 W. York St.
Kempf, Mrs. Gerald F.....Indiana State Hospital for Chest Diseases
Minich, Mrs. William G.....617 Woodland Dr.

## PERRY-SPENCER COUNTIES

Bush, Mrs. Hargis R.....Sixth St., Cannelton
Gilbert, Mrs. Robert G.
411 E. Seventh St., Cannelton
Glackman, Mrs. John C. 207 Center St., Rockport
Snyder, Mrs. Earl.....Troy

### Tell City

Dukes, Mrs. David A.....521 Main St.
Herr, Mrs. William J.....Boyd Road
James, Mrs. Nicholas A.....740 Ninth St.
Lally, Mrs. Bernard.....918 Main St.
Lohoff, Mrs. Lewis C.....425 10th St.
Neifert, Mrs. Noel L.....1118 Blum St.
Ress, Mrs. Gene E.....1530 13th St.
Smith, Mrs. Fred, Jr.....1407 12th Street

## PORTER COUNTY

### Chesterton

Hall, Mrs. Thomas.....16 Ridge Dr., Dune Acres
Harless, Mrs. C. M.....123 W. Indiana Ave.
Robertson, Mrs. W. C.....600 E. Morgan

### Valparaiso

Brown, Mrs. J. C.....1808 Napoleon
Carlson, Mrs. M. R.....2206 Vine St.
DeGrazia, Mrs. E. J.....410 Washington St.
Eades, Mrs. Ralph.....203 Jefferson St.
Frank, Mrs. John R.....303 Indiana Ave.
Gold, Mrs. Marvin E.....1407 Washington St.
Kilmer, Mrs. Warren.....305 Spectacle Dr.
Klos, Mrs. Stanley J.....2403 Sears St.
Lands, Mrs. Robert M.....Saturn Lane
LaRocca, Mrs. Joseph.....402 Erie
Makovsky, Mrs. Theodore..1807 Beulah Vista Dr.
O'Neill, Mrs. Martin J.....301 Washington St.
Sacks, Mrs. Leonard Z.....563 Ravine Dr.
Vietzke, Mrs. Paul C. F.....1302 Summit Pl.
Wu, Mrs. Stewart.....102 Mayfield Ave.

## PUTNAM COUNTY

Veach, Mrs. Richard L.....Bainbridge
Ellett, Mrs. John.....Box 126, Coatesville

### Greencastle

Dettloff, Mrs. Frederick R.....300 Highfall Ave.
Johnson, Mrs. James B.....314 Highfall Ave.
Jones, Mrs. Lawrence.....R. R. 2
Lett, Mrs. James.....335 Greenwood
Schauwecker, Mrs. Cleon M.....613 Ridge Ave.
Smith, Mrs. A. Wilson.....R. F. D. 2
Steele, Mrs. Dick J.....207 Northwood Blvd.
Stephens, Mrs. James P.....R. R. 3
Thompson, Mrs. Edward.....8 Kentwood Dr.
Tipton, Mrs. William R.....103 Northwood Blvd.
Wiseman, Mrs. V. Earle.....6 Durham Ave.

## RANDOLPH COUNTY

### Farmland

Nixon, Mrs. Byron.....312 N. Main
White, Mrs. Harvey E.....200 S. Main

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Shallenberger, Mrs. H. R.....Modoc
Potter, Mrs. Richard M.
120 N. Walnut, Ridgeville

### Union City

Chambers, Mrs. Carol R.....1000 N. Columbia St.
Chambers, Mrs. Leroy B.....800 N. Columbia St.
Landon, Mrs. David J.....623 N. Columbia St.
Phipps, Mrs. Leland K.....R. R. 1, Box 63A
Reid, Mrs. Robert W.....706 W. Division
Wagoner, Mrs. B. D.....409 N. Columbia St.

### Winchester

Dininger, Mrs. William S.....303 S. Main St.
Engle, Mrs. Russell B.....R. R. 2
Painter, Mrs. Lowell W.....507 S. Main St.
Slick, Mrs. C. R.....512 S. Oak St.
Sparks, Mrs. Paul W.....601 W. Will

## RUSH COUNTY

McNabb, Mrs. George B.....Carthage
Smith, Mrs. Stephen D.
304 N. Washington, Knightstown
Worth, Mrs. C. Willard.....Milroy

### Rushville

Atkins, Mrs. C. C.....410 N. Perkins
Corpe, Mrs. Kenneth F.....R. R. 4
Ellis, Mrs. Davis W.....1102 Sugar Hill Dr.
Green, Mrs. Frank H.....516 N. Morgan
McKee, Mrs. Harry G.....1109 N. Arthur St.
McKee, Mrs. Harry.....R. R. 6
Norris, Mrs. Marvin.....1107 N. Main St.
Schneider, Mrs. Marvin.....431 N. Perkins St.
Shanks, Mrs. Roy E.....1110 N. Morgan

## ST. JOSEPH COUNTY

Houser, Mrs. D. S.
24751 N. Riley Rd., North Liberty

### Mishawaka

Barone, Mrs. C. V.....59053 Bremen Highway
Ganser, Mrs. Richard A.....1020 Wilson Blvd.
Gerig, Mrs. E. Lavern.....713 W. 11th St.
Goethals, Mrs. Charles J.....602 Lincoln Way W.
Orr, Mrs. W. Robert.....1335 Prospect Dr.
Reed, Mrs. Robert.....903 Homewood
Roberts, Mrs. Billy J.....15605 Hearthstone Dr.
Rosenwasser, Mrs. Jacob.....834 Lincoln Way E.
Spalding, Mrs. Wendell L.....60100 S. Fir Road
Stringer, Mrs. D. D.....1035 Lincoln Way E.
Templeton, Mrs. Ames R.....522 Calhoun St.
Walters, Mrs. Charles E.....16166 Ireland Rd.
Whitlock, Mrs. Francis C.....304 Lincoln Way E.
Whitlock, Mrs. Merle E.....16146 Chandler Blvd.
Wurster, Mrs. H. C.....221 E. Third St.
Zimmer, Mrs. Henry J.....333 Edgewater Dr.

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Spenner, Mrs. Raymond W.
R. R. 3, Diamond Lake, Cassopolis, Mich.

### South Bend

A

Acker, Mrs. Robert B.....103 S. Ironwood Dr.
Arisman, Mrs. R. K.....1615 E. Colfax Ave.

B

Backs, Mrs. Alton J.....1831 N. Kessler Blvd.
Baran, Mrs. Charles.....1808 E. Jefferson Blvd.
Bartsch, Mrs. Harvey L.....61397 S. Miami Rd.
Beach, Mrs. Norman.....1903 Trent Way
Bebensee, Mrs. Donald.....53263 Ironwood Dr.
Bechtold, Mrs. Samuel E.....313 Pendle St.
Bell, Mrs. H. D.....1357 E. Champeau St.
Bell, Mrs. R. L.....109 S. Ellsworth
Bennett, Mrs. Jene R.....1826 E. Jefferson Blvd.
Berke, Mrs. Robert D.....1420 E. Jefferson Blvd.
Biasini, Mrs. Ben A.....19585 Glendale Road
Bickel, Mrs. David A.....1335 E. Wayne St. N.
Birmingham, Mrs. P. J... 61490 Meadowlark Lane
Bixler, Mrs. Louis C.....1817 Portage Ave.
Bodnar, Mrs. Leslie M.....1843 Portage Ave.
Bogan, Mrs. Wm. C.....1512 Hass Dr.
Borough, Mrs. Lester D.....24030 Cleveland Rd.

Brechtl, Mrs. H. J.....2305 E. Washington
Broghammer, Mrs. Ben J.....1912 Trent Way
Buchanan, Mrs. Wallace D. 1326 E. Wayne St., N.
Buechner, Mrs. Fred W.....603 W. Marion St.
Buslee, Mrs. Roger M.....524 S. Twyckenham
Butts, Mrs. Milton A.....744 N. Jacobs St.

C

Cassady, Mrs. John R.....2225 Riverside Dr.
Cassady, Mrs. J. Vernal.....2216 E. Madison
Chamblee, Mrs. Roland W.....53287 Ironwood Rd.
Clark, Mrs. William H.....1227 Garland Rd.
Colip, Mrs. George D.....260 David St.
Cook, Mrs. Gordon C.....1620 Southwood Ave.
Custer, Mrs. Edward W.....52383 N. Laurel Rd.

D

Davis, Mrs. Edward A.....52820 Kenilworth Rd.
Denham, Mrs. Robert H., Jr.....1515 E. Colfax
DeVoe, Mrs. K. R.....52978 Highland Dr.
Dingley, Mrs. Albert, Jr.....1309 E. Wayne St. S.
Dodd, Mrs. Robert D.....1510 Tudor Lane
Dolezal, Mrs. Bernard J....425 W. North Shore Dr.
Donnelly, Mrs. Everett F. 1246 E. Jefferson Blvd.
Dunlap, Mrs. D. Logan....123 W. North Shore Dr.

E

Eades, Mrs. R. Charles.....232 Marquette Ave.
Egan, Mrs. Sherman L.....944 Riverside Dr.
Engel, Mrs. Howard R.....1845 Ridgewood Circle
English, Mrs. J. Paul.....3116 Robinhood Lane
Erickson, Mrs. G. Walter....3012 Robinhood Lane

F

Feferman, Mrs. Martin E.....125 S. Esther St.
Filipek, Mrs. Walter J.....2513 Lincoln Way W.
Firestein, Mrs. Ben Z.....125 W. Marion St.
Firestein, Mrs. Ray.....502 N. Ironwood Dr.
Fish, Mrs. Edson C.....19054 Summers Dr.
Foley, Mrs. Hansel.....1314 Leeper
Forrest, Mrs. O. Norman.....52725 Arbor Dr.
Frank, Mrs. Herbert....2616 S. Twyckenham Dr.
Frank, Mrs. L. L., Sr.....534 N. Lafayette Blvd.
Frank, Mrs. L. L., Jr.....1750 N. Wilbur
Frey, Mrs. William B.....1714 E. Bader
Friedman, Mrs. Morris S...1617 E. Jefferson Blvd.

G

Ganser, Mrs. Ralph.....18805 E. Jackson Rd.
Gates, Mrs. George E...411 W. North Shore Dr.
Gilman, Mrs. Marcus M...1925 E. Jefferson Blvd.
Godersky, Mrs. George E.....2744 Sampson St.
Goraczewski, Mrs. T. C.....1016 W. Washington
Graf, Mrs. John P.....53260 Placid Dr.
Green, Mrs. G. Richard.....1515 E. Wayne St.
Green, Mrs. George F.....754 Country Club Lane
Green, Mrs. Norval E.....1726 E. LaSalle Ave.
Grove, Mrs. James H.....60268 Mayflower Rd.

H

Haley, Mrs. George M.....19120 Montrose Dr.
Hamilton, Mrs. Charles O.
1418 E. Washington Ave.
Haugseth, Mrs. Ellsworth K...820 N. Ironwood Dr.
Hawkins, Mrs. Glen E.....17280 Parker Ave.
Helmer, Mrs. John.....315 W. North Shore Dr.
Hildebrand, Mrs. J. O.....1637 Southbrook Dr.
Hill, Mrs. Theodore.....107 N. Eddy St.
Hill, Mrs. Wallace C.....248 S. Hawthorne
Holtzman, Mrs. Norman.....3322 Whitcomb
Hyde, Mrs. Carroll C.....1521 E. Colfax Ave.

J-K

Jankowski, Mrs. Ernest B.....2230 Ribourde
Kamm, Mrs. Bernard A.....125 W. Marion St.
Karn, Mrs. John W.....1535 Wall St.
Krueger, Mrs. John E.....620 E. Peashway
Kuhn, Mrs. Frederick L.....1215 S. Michigan St.

L

Lester, Mrs. Vern L.....3536 Springbrook Dr.
Levatin, Mrs. Bernard I.....1814 Churchill Dr.
Levkoff, Mrs. Abner H...1815 E. Jefferson Blvd.
Lionberger, Mrs. John R. 1419 E. Jefferson Blvd.
Liss, Mrs. Emanuel C.....1228 E. Jefferson Blvd.
Lockhart, Mrs. Philip B.....1611 Wayne St. E.

M

Macri, Mrs. Paul A.....1601 E. Cedar
Mahank, Mrs. Camiel C...1804 E. Jefferson Blvd.
Marquis, Mrs. Gordon.....329 Wakewa
Mason, Mrs. Bernard A.....2719 Marine St.
Mauzy, Mrs. Merritt C.....1740 Hass Dr.
McCraley, Mrs. William J.....1737 Belmont Ave.
Metcalfe, Mrs. Grant E.....1209 E. Wayne St., N.
Mott, Mrs. C. A.....2733 Lincoln Way West
Mueller, Mrs. Hilbert M...3525 Windingwood Dr.
Murphy, Mrs. Eugene C.....1411 Sunnymede Ave.
Murphy, Dr. Josephine.....505 W. LaSalle Ave.
Myers, Mrs. Philip R.....1147 Cleveland Ave.

N-O

Neher, Mrs. John L.....17371 Cleveland Rd.
Nelson, Mrs. Raymond E.....1909 E. Madison St.
Olson, Mrs. Donald T.....1806 Cedar St.
Olson, Mrs. Kenneth L.....1228 E. Woodside Ave.
Oren, Mrs. William.....1149 E. Belmont

P

Pairitz, Mrs. Frank.....1436 Sunnymede Ave.
Parsons, Mrs. Robert.....1464 Ridgedale Rd.
Pascuzzi, Mrs. Chris A.....1930 Dorwood Dr.
Pauszek, Mrs. Thomas B.....916 Riverside Dr.
Petrass, Mrs. Andrew....22027 Liberty Highway
Phelps, Mrs. Stephen R.....1331 Sunnymede Ave.
Plain, Mrs. George.....17836 Ponader Dr.
Pyle, Mrs. H. Dale.....115 N. Sunnyside Ave.

R

Rigley, Mrs. Edward L.....1704 Ridgedale Rd.
Rosenheimer, Mrs. George M...1425 E. Woodside
Rubens, Mrs. Eli.....1240 E. Irvington

S

Sanderson, Mrs. Robert B...238 S. Hawthorne Dr.
Sandock, Mrs. Louis F.....235 S. Esther St.
Sandoz, Mrs. Harry H.....239 S. Hawthorne Dr.
Schaphorst, Mrs. Richard A...514 Lincoln Way E.
Schiller, Mrs. Herbert A.....1813 E. Cedar St.
Scott, Mrs. Frank M.....1220 E. Woodside
Selby, Mrs. Keith E.....1327 E. Wayne St., N.
Sellers, Mrs. Francis.....814 Oakridge Dr.
Sharp, Mrs. Merle C.....17780 Waxwing Lane
Shriber, Mrs. Wm. H.....1512 E. Madison
Shriner, Mrs. Richard.....53362 Juniper Rd.
Sisson, Mrs. Norvel D.....1614 Oak Park Dr.
Skillern, Mrs. Scott.....1553 Southbrook Dr.
Slominski, Mrs. Harry H.....1862 College St.
Staunton, Mrs. Henry A.....124 S. 34th St.
Stiver, Mrs. Dan D.....1127 E. Wayne St. N.
Stogdill, Mrs. William J.....520 N. Coquillard Dr.
Stratigos, Mrs. Joseph S.....527 N. Lafayette

T

Thompson, Mrs. John M.....1618 E. Cedar St.
Thornton, Mrs. M. J.....125 W. Marion St.
Tirman, Mrs. Wallace S.....1224 E. Wayne St., N.

V-W-Z

Vagner, Mrs. Bernard S.....53190 Willow Run Rd.
Van Fleit, Mrs. W. E.....1617 E. Cedar St.
Vurpillat, Mrs. F. J.....2102 E. Cedar St.
Weiss, Mrs. Eugene.....1605 E. Washington Ave.
White, Mrs. Donald G.....1721 E. Altgeld

Wilson, Mrs. James M.....1507 E. Wayne
Zeiger, Mrs. Irvin L.....1205 E. Irvington

## SHELBY COUNTY

Davis, Mrs. John A.....Flat Rock

**Shelbyville**

Arata, Mrs. Lucian A.....327 W. Broadway
Dalton, Mrs. Wilson L.....1712 Culbertson
Deupree, Mrs. William D.....50 W. Mechanic St.
Gehres, Mrs. Robert W.....610 Shelby St.
Green, Mrs. William L.....Country Club Heights
Inlow, Mrs. Paul M.....104 W. Washington St.
Inlow, Mrs. Robert.....424 Lockerbie
Inlow, Mrs. W. D.....Spring Hill Rd.
McFadden, Miss Marian.....28 W. Mechanic St.
McFadden, Mrs. Walter C.....28 W. Mechanic St.
Moheban, Mrs. Joseph.....Spring Hill Rd.
Paz, Mrs. Luis.....526 E. McKay Rd.
Phares, Miss Frances.....408 S. Harrison
Richard, Mrs. Norman F.....Country Club Heights
Scott, Mrs. V. Brown.....R. R. 2, N. Riley Hwy.
Silbert, Mrs. David B.....1100 Fairfield Dr.
Spindler, Mrs. Robert D.....165 W. Mechanic St.
Tindall, Mrs. William R.....616 S. Harrison
Tower, Mrs. James H., Jr...239 W. Washington St.
Whitcomb, Mrs. Roger F.....218 W. Broadway

## STARKE COUNTY

Leinbach, Mrs. Earl R.....206 Davis, Hamlet
DeNaut, Mrs. James F.....201 E. Lake St., Knox
Henry, Mrs. Howard J.....R. R. 1, Knox
Ingwell, Mrs. Guy B.....402 E. Lake St., Knox
McClure, Mrs. Clark.....R. R. 1, Knox
Palmer, Mrs. Alan.....303 E. Lake St., Knox

## TIPPECANOE COUNTY

**Lafayette**

Babb, Mrs. Forrest J.....2106 S. Ninth St.
Bayley, Mrs. William E. .....303 S. Ninth St.
Bridge, Mrs. Barton C.....22 Thise Ct.
Buhrmester, Mrs. Harry C.....Freiberger Lane
Carpenter, Mrs. James B.....R. R. 5
DuBois, Mrs. Ramon B.....519 Calvert Lane
Flack, Mrs. Russell A.....3600 Cypress Lane
Harvey, Mrs. Bennett B.....2908 Beverly Lane
Holladay, Mrs. Lloyd J.....1403 S. 14th St.
Horswell, Mrs. Richard R.....2312 Dakota Dr.
Karberg, Mrs. Richard J.....1212 El Prado
Kohne, Mrs. Robert W.....1001 Pontiac
Landis, Mrs. Charles B.....505 S. 17th St.
McAdams, Mrs. Hugh B.....2110 Birch Lane
McClelland, Mrs. Donald C...1021 Highland Ave.
McPherson, Mrs. Richard C.....1603 S. Fifth St.
Miller, Mrs. Albert J.....927 Highland Ave.
Miller, Mrs. Wm. J.....920 Beck Lane
Neumann, Mrs. Kenneth O.....1410 S. 18th St.
Ratcliff, Mrs. Frank W.....1000 Wea Ave.
Ricchetti, Mrs. Warren.....3134 Longlois
Sholty, Mrs. William M.....Shadeland Farm Rd.
Smith, Mrs. Lowell C.....615 Lingle
Trout, Mrs. Carl J.....800 State St.
Underwood, Mrs. George M.....2540 Lafayette Dr.
Vermilya, Mrs. Robert W..R. R. 5, Cedar Bluff Rd.

**West Lafayette**

Beuerman, Mrs. Virgil A.....509 Emily St.
Bolin, Mrs. Robert C.....908 Windsor Dr.
Burns, Mrs. John T.....100 Tecumseh Park Lane
Bush, Mrs. Jack A.....108 Creighton Rd.
Canganelli, Mrs. Vincent G.....108 Mohawk Lane
Carpenter, Mrs. Robert
Williamsburg Apt., North River Rd.
Davis, Mrs. Howard B.....833 Hillcrest Rd.
Elliott, Mrs. Paul W.....348 W. Stadium Dr.
Heid, Mrs. George J.....1704 Summit Rd.
Hull, Mrs. James E.....328 Leslie Ct.
Keplinger, Mrs. James.....136 E. Navajo
Klatch, Mrs. Ben Z.....1415 Woodland Dr.
Loop, Mrs. Frederick A.....119 Leslie Dr.
Marvel, Mrs. Howard R.....136 Arrowhead Dr.
McAdams, Mrs. Robert C. .....625 Ridgewood Dr.
McFadden, Mrs. James M.....1424 N. Salisbury
Mather, Mrs. Charles R.....1815 Ravina Rd.
Mount, Mrs. William M.....217 Pawnee Dr.
Riggs, Mrs. W. A.....507 Sharon Rd.
Shively, Mrs. John L.....205 Lindberg Ave.
Spurlock, Mrs. F. H.....1625 Western Dr
Stahl, Mrs. Edward T.....324 Park Lane
VanDen Bosch, Mrs. W. R.....715 Princess Dr.
Wagoner, Mrs. A. R.....1834 Summit Dr.
Washburn, Mrs. Mary.....209 Forest Hill Dr.
Weller, Mrs. Wendell A.....105 Pawnee Dr.

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Baker, Mrs. John R.....Heath Rd., Buck Creek
Weller, Mrs. Ralph.....Box 38, Rossville

## VANDERBURGH COUNTY

**Evansville**

A

Acre, Mrs. Robert R.....2311 Lincoln Ave.
Adler, Mrs. Ray N.....1660 Lincoln Ave.
Adye, Mrs. Wallace M.....320 Inwood Dr.
Alexander, Mrs. John E.....7720 Lauderdale Dr.
Antes, Mrs. Earl H.....1201 Bonnie View Dr.
Arendell, Mrs. Robert E....710 S. Weinbach Ave.
Austin, Mrs. Eugene W...2163 Bayard Park Dr.

B

Baker, Mrs. Mason R.....4500 E. Cherry St.
Barnhart, Mrs. Willard T.....507 S. Boeke Rd.
Beck, Mrs. Robert E.....6000 Newburgh Rd.
Beisel, Mrs. Larry H.....1427 Lark
Bender, Mrs. Martin J.....2416 Bayard Park Dr.
Bennett, Mrs. Abner P.....961 Blue Ridge Rd.
Bissonnette, Mrs. Roger P.....911 Colony Rd.
Bloss, Mrs. Bryant A.....8006 Heather Court
Boone, Mrs. Robert D.....417 S. Alvord Blvd.
Brakel, Mrs. Frank, Jr.....1429 Oriole Dr.
Britt, Mrs. Robert L.....6317 Newburgh Rd.
Brockmole, Mrs. Arnold W.
5901 New Harmony Rd.
Brown, Mrs. George W.....757 S. Lombard
Bryan, Mrs. Stanton L.....3211 E. Mulberry St.
Buddrus, Mrs. David.....508 S. Boeke Rd.
Buehner, Mrs. Donald F.....1200 Bonnie View Dr.
Burger, Mrs. Thomas C.....3915 Washington Ave.
Burnikel, Mrs. Ray H.....960 S. Rotherwood Ave.
Burress, Mrs. Clyde.....10100 Old St. Rd.

C

Cacia, Mrs. John J.....420 S. Boeke Rd.
Carlson, Mrs. Ralph F.....1350 Bayard Park Dr.
Cates, Mrs. Jeryl.....647 Plaza Dr.
Clark, Mrs. Thomas W.....820 S. Meadow Rd.
Clouse, Mrs. Paul A.....5801 Newburgh Rd.
Coleman, Mrs. Joseph E.....2831 Wayside Dr.
Colvin, Mrs. Robert.....2048 Polaris
Combs, Mrs. Herman.....915 S. Red Bank Rd.
Cooper, Mrs. Waller W.....4410 Oak St.
Corcoran, Mrs. P. J. V.....2412 E. Chandler Ave.
Crawford, Mrs. James.....631 Blue Ridge Dr. W.
Crevello, Mrs. Albert J.....1664 Lincoln Ave.
Cullnane, Mrs. Chris W.....3020 Mt. Vernon Ave.

D

Daves, Mrs. W. Lawrence.....708 College Hwy.
Davidson, Mrs. Harold H.....800 Blue Ridge Rd.
Davis, Mrs. Max D.....1426 Lark
Deems, Mrs. Myers.....6830 Arcadian Highway
Denzer, Mrs. Edward K.....540 Scenic Dr.
Denzer, Mrs. William O.....923 Bellemeade
Dieckman, Mrs. Herbert S.....10 Johnson Place
Dodd, Mrs. R. K.....1705 S. New Green River Rd.

Durkee, Mrs. Melvin S.....615 Trinity Dr.
Durkin, Mrs. John W., Jr.....2524 Adams St.
Dycus, Mrs. Walter A.....3400 Koring Rd.
Dyer, Mrs. Wallace K.....812 St. James Blvd.

E

Ebin, Mrs. J. L.....8500 Whetstone
Engel, Mrs. Edgar L.....1411 E. Park Dr.
Ewer, Mrs. Robert W.....7226 E. Blackford

F

Faith, Mrs. Ira L.....950 Blue Ridge Rd.
Faul, Mrs. Henry J.....725 S. Willow Rd.
Faw, Mrs. Melvin L.....2400 E. Chandler
Fenneman, Mrs. Robert J.
Box 145, R. R. 8, Old St. Rd.
Fisher, Mrs. William C.....1319 S. Kentucky
Fitzsimmons, Mrs. Elvin L.....500 S. Boeke Rd.

G

Garland, Mrs. Edgar A.....719 Plaza Dr.
Garst, Mrs. Garland.....1928 Theatre Dr.
Gaul, Mrs. L. Edward.....18 Johnson Pl.
Geller, Mrs. Samuel.....R. R. 8, Box 143-A
Getty, Mrs. William H.....1810 Mt. Auburn Rd.
Giorgio, Mrs. Douglas J.....916 S. Burkhardt Rd.
Gourieux, Mrs. E. DeVerre.....7500 Taylor Ave.
Griep, Mrs. Arthur H.....5414 Madison Ave.
Grimm, Mrs. William C...513 S. Rotherwood Ave.
Guckien, Mrs. Joseph.....2301 E. Powell

H

Hammond, Mrs. R. Case.....6820 Arcadian Hwy.
Hare, Mrs. Daniel M.....5029 Lincoln Ave.
Harlan, Mrs. William L.....731 S. Frederick
Harned, Mrs. Ben King, Jr.....8232 Maple Lane
Harris, Mrs. Robert L.....870 S. Boeke Rd.
Hart, Mrs. L. Paul.....622 Trinity Dr.
Hartley, Mrs. Clarence A., Jr.....300 Hesmer Rd.
Hassel, Mrs. Walter.....3712 Herndon Dr.
Heinrich, Mrs. Weston A.....1408 Lincoln Ave.
Hendershot, Mrs. Eugene L...7006 Newburgh Rd.
Hermayer, Mrs. Stephen....1316 Bonnie View Dr.
Herrmann, Mrs. Gordon T.....218 S. Spring St.
Herzer, Mrs. Clarence C.....211 E. Mill Rd.
Himebaugh, Mrs. Gilbert J.....408 S. Alvord Blvd.
Hobgood, Mrs. James L.....6400 Jefferson
Hoover, Mrs. J. Guy.....864 Lodge Ave.
Hovda, Mrs. Richard B.....800 St. James Blvd.
Huggins, Mrs. Victor S.....520 S. Alvord Blvd.
Hyatt, Mrs. Gilbert T.....1616 Mt. Auburn Rd.

J-K

Johnson, Mrs. Harold V.....1303 Masker Pk. Dr.
Johnson, Mrs. Stephen L.....2215 Lincoln Ave.
Kelley, Mrs. John B.....1420 Lark Dr.
Kiechle, Mrs. Fred L.....726 S. E. First St.
Kimmel, Mrs. George.....429 S. St. James
Kincaid, Mrs. Robert S.....5417 Stringtown Rd.

L

Lashley, Mrs. Donald.....1406 Martin Lane
Laubscher, Mrs. Clarence A...1201 Laubscher Rd.
Lawrence, Mrs. Joseph C. 1362 E. Chandler Ave.
Liebundguth, Mrs. Henry.....5206 Lincoln Ave.
Lessure, Mrs. Alfred P.....3105 E. Oak St.
Lewis, Mrs. Earl T.....807 S. Burkhardt
Logan, Mrs. Jesse R.....503 First Ave.
Longstaff, Mrs. John.....5913 Washington

M

MacKenzie, Mrs. Pierce.....2300 E. Gum St.
McCool, Mrs. Joe H.....#1 Woodmere Lane
McDonald, Mrs. Joseph D.....4300 Lincoln Ave.
McPherson, Mrs. Tom.....1612 Southeast Blvd.
Marvel, Mrs. James A.....1431 Green Meadow
Mathews, Mrs. James R.....901 Meadow Rd.
Miller, Mrs. LaVerne B.....501 Scenic Dr.
Miller, Mrs. Milton J.....8201 Newburgh Rd.
Mills, Mrs. Fred E.....555 S. Kelsey Ave.
Mino, Mrs. Robert A.....2808 N. Shore Dr.
Mullican, Mrs. Wm.....3007 Taylor

N

Newnum, Mrs. Raymond L.....727 College Hwy.
Nicholson, Mrs. Raymond W...1467 Southfield Rd.
Nonte, Mrs. Leo R.....714 S. Willow Rd.

O

Oswald, Mrs. Robert H.....2423 Lincoln Ave.

P

Pastor, Mrs. Julius W.....5901 Washington Ave.
Pavlick, Mrs. Theodore J.....4212 Jennings Lane
Pemberton, Mrs. Jack J.....Falstead Rd., R. R. 1
Pollard, Mrs. Walter S.....6300 Felstead Rd.
Porro, Mrs. Francis W.....909 S. Villa Dr.
Present, Mrs. Julian D.....201 S. Parker Dr.
Pugh, Mrs. Willis L.....5204 Lincoln Ave.

R

Radcliff, Mrs. Forest F., Jr.....763 S. Weinbach
Ratcliffe, Mrs. Albert W.....510 S. E. First St.
Reich, Mrs. Clarence E.....1209 N. Fulton Ave.
Richey, Mrs. Clifford O.....407 Congress Ave.
Rietman, Mrs. H. Jerome.....2325 Lincoln Ave.
Rininger, Mrs. Harold C.....2154 E. Gum St.
Ritchie, Mrs. William D.....5201 Stringtown Rd.
Ritz, Mrs. Albert S.....765 S. Boeke Rd.
Rosenblatt, Mrs. Bernard B...626 St. James Blvd.
Royster, Mrs. Robert A.....34 Johnson Place
Ruddick, Mrs. Hobart.....Regina Pacis Home
Rudolph, Mrs. Kenneth.....742 Plaza Dr.
Rupper, Mrs. Warren R.
Heckle Rd., Box 159, R. R. 3
Russell, Mrs. Richard H.....1015 Harrelton Ct.

S

Schimmelpfennig, Mrs. Robert W.
3014 Washington Ave.
Schirmer, Mrs. Robert H.....2710 Hartmetz Ave.
Schneider, Mrs. Charles P...2924 W. Maryland St.
Sheehan, Mrs. E. Gregg.....934 York Rd.
Shively, Mrs. Wyant J.....1409 Martins Lane
Sinn, Mrs. Charles M.....1509 Redwing Dr.
Slaughter, Mrs. Howard C.....651 St. Mary's Dr.
Slaughter, Mrs. John C.....622 College Hwy.
Slaughter, Mrs. Owen L.....506 St. James Blvd. S.
Smith, Mrs. Roy M.....417 Senate
Spain, Mrs. Thomas.....400 Runnymeade Ave.
Sprecher, Mrs. Herman C.....6601 Newburgh Road
Springstun, Mrs. W. Russel.....854 Lodge Ave.
Stallings, Mrs. Hugh A.....7601 Newburgh Rd.
Sterne, Mrs. John H.....2308 E. Gum St.
Stewart, Mrs. L. Ray.....852 S. Alvord Blvd.
Stork, Mrs. Urban.....856 S. Alvord Blvd.
Strueh, Mrs. Paul E.....1207 Harrelton Ct.

T

Tager, Mrs. Stephen N.....700 S. Meadow Rd.
Tisserand, Mrs. John B. Jr.....637 College Hwy.
Tuholski, Mrs. James M.....520 S. Roosevelt Dr.
Tweedall, Mrs. Daniel C.....900 S. Meadow Rd.

V-W

Venables, Mrs. A. J.....420 Runnymeade
Visher, Mrs. John W.....510 E. Mt. Pleasant Rd.
VonderHaar, Mrs. Thomas E.
901 S. Burkhardt Rd.
Walker, Mrs. William F.....1220 Cullen Ave.
Walter, Mrs. Robert F.....1514 S. Kentucky Ave.
Warner, Mrs. Charles L.....4120 Bellemeade Ave.
Waters, Mrs. George E.....2 Woodmere Dr.
Weiss, Mrs. H. G.....1014 E. Powell Ave.
Welborn, Mrs. Mell B.....1832 Mt. Auburn Rd.
Wilhelmus, Mrs. C. Kenneth..6929 Newburgh Rd.
Wilhelmus, Mrs. Gilbert M...5901 Newburgh Rd.
Willison, Mrs. George W.....605 St. Mary's Dr.
Wilson, Mrs. David.....1709 Southeast Blvd.

Wilson, Mrs. John D.....921 Colony Rd.
Wilson, Mrs. Ralph.....1522 Audubon Dr.
Woodson, Mrs. Dan.....414 S. Kelsey
Woodward, Mrs. Ben E.....1032 Rosemarie Ave.
Wynn, Mrs. Justice F.....651 S. Weinbach Ave.

Y-Z

Young, Mrs. C. Curtis, Jr.....2327 Lincoln Ave.
Zeier, Mrs. Francis G.....3708 Mulberry

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Stover, Mrs. Wendell C.
20 Lake Shore Drive, Boonville
Crist, Mrs. John R.....320 Emmick, Mt. Vernon
Hirsch, Mrs. H. L...801 Williams Dr., Mt. Vernon
Oliphant, Mrs. Frank W.
701 Mulberry St., Mt. Vernon
Vogel, Mrs. John L...530 E. Fifth St., Mt. Vernon
Rusche, Mrs. Henry J.....Hwy. 261, Newburgh
Zwickel, Mrs. R. E.....Darby Hills, Newburgh
Ropp, Mrs. Harold E...Church St., New Harmony
Smith, Mrs. Gordon L.....R. R. 2, New Harmony

## VIGO COUNTY

Speas, Mrs. Robert C.....Box 22, Seelyville

**Terre Haute**

A

Allen, Mrs. William H.....2605 N. 9th St.
Anderson, Mrs. W. C.....380 S. 22nd St.
Ault, Mrs. Roy J.....200 Lakeview Dr.

B

Bannon, Mrs. William G.....2126 Ohio Blvd.
Blum, Mrs. Leon L.....3200 Ohio Blvd.
Bopp, Mrs. Henry W., Jr.....73 Allendale Pl.
Bopp, Mrs. Henry W., Sr.....132 Barton Ave.
Bopp, Mrs. James.....330 Hamilton Dr.
Boyd, Mrs. H. Clark.....44 Long Ridge Rd.
Brown, Mrs. Robert R.....2544 N. Ninth St.
Burkle, Mrs. Robert J.....128 Gardendale Rd.

C-D

CaJacob, Mrs. Melville E.....1000 S. Sixth St.
Caldwell, Mrs. M. V.....R. R. 7, Box 449
Carpenter, Mrs. Donald J.....125 S. 20th St.
Conforti, Mrs. Victor P.....2540 N. 10th St.
Conway, Mrs. Thomas J.....207 Barton Ave.
Crockett, Mrs. Wayne A.....3601 Ohio Blvd.
Davis, Mrs. Paul E.....3301 N. Center St.
Dierdorf, Mrs. Fred.....103 S. 23rd St.
Drummy, Mrs. W. W., Jr.....231 Fruitridge
Dyer, Mrs. G. Wallace.....2710 Wilson Dr.

E-F

Freed, Mrs. John E., Sr.....2408 N. 10th St.
Freed, Mrs. John E., Jr.....2425 N. Eighth St.

G

Gerrish, Mrs. Don A.....5206 Clinton Rd.
Gilbert, Mrs. Ivan.....2641 Crawford St.
Gillotte, Mrs. J. P.....49 Bogart Dr.
Goodman, Mrs. Hubert T.....220 Gardendale Rd.
Gossom, Mrs. Donn R.....1904 Ohio Blvd.

H

Haslem, Mrs. Ezra R.....30 Circle Dr.
Haslem, Mrs. John R.....2501 Poplar St.
Hogan, Mrs. Thomas W.....332 S. 31st St.
Humphrey, Mrs. Paul E.....2631 N. Ninth St.

J-K

Johnson, Mrs. Edward.....313 Terre Vista Dr.
Johnson, Mrs. Paul D., Jr.....3101 Poplar St.
Kabel, Mrs. Robert N.....2201 Ohio Blvd.
Kunkler, Mrs. Arnold W.....147 Monterey Ave.

L

Lancet, Mrs. Robert O.....20 Nitche Dr.
Lee, Mrs. James C.....12 32nd St. Ct.
Loewenstein, Mrs. Werner L.....1909 Ohio Blvd.
Luckett, Mrs. C. L.....R. R. 2
Lyons, Mrs. L. Mason.....123 S. 21st St.

M

McAleese, Mrs. George.....2306 N. 10th St.
McBride, Mrs. Noel S.....67 Allendale Pl.
McCrea, Mrs. Fred R.....2517 N. Eighth St.
McEwen, Mrs. James W.....107 Wren Dr.
McLaughlin, Mrs. Gordon.....R. R. 3, Box 128
Mahoney, Mrs. Charles L.....6800 Dixie Bee Rd.
Malone, Mrs. L. A.....2511 N. Ninth St.
Mankin, Mrs. William.....175 Lakeview Dr.
Mason, Mrs. Lester M.....66 Allendale Pl.
Mattox, Mrs. Don M.....240 Hamilton Dr.
Mattox, Mrs. Ernest.....240 Hamilton Dr.
Meissel, Mrs. Robert L.....10 Monroe Blvd.
Miklozek, Mrs. J. E.....2204 Ohio Blvd.
Mitchell, Mrs. John R.....2421 Ohio Blvd.
Musselman, Mrs. Glen.....7222 Wabash Ave.

N-O-P

Nay, Mrs. Ernest O.....29 S. 20th St.
Neudorff, Mrs. Louis G.....213 Barton Ave.
Oliphant, Mrs. Robert W.....8 31st St. Ct.
Pearce, Mrs. Roy V.....269 S. 26th St. Dr.
Pu, Mrs. Pin H.....230 Briarwood Dr.

R

Reed, Mrs. Robert C.....1933 S. Center St.
Reynolds, Mrs. Richard J.....72 Allendale Pl.
Richart, Mrs. James V.....336 Hamilton Dr.
Rourke, Mrs. Robert F.....R. R. 4
Rubin, Mrs. Milton M.....2401 Ohio Blvd.

S

Scherb, Mrs. Burton E.....211 Gardendale Rd.
Schott, Mrs. Edward J.....653 Oak St.
Schumaker, Mrs. Robert A.....R. R. 4
Scully, Mrs. William E.....2649 Oak St.
Showalter, Mrs. John R., Jr...2511 N. Eighth St.
Siebenmorgen, Mrs. Paul.....2515 N. Seventh St.
Silverman, Mrs. Norman M.....1142 S. Center St.
Stoelting, Mrs. J. Lewis.....1919 N. Seventh St.
Strecker, Mrs. William L.....88 Allendale Pl.
Sullivan, Mrs. John M.....2242 College Ave.

T-V

Topping, Mrs. Malachi C.....3505 Ohio Blvd.
Veach, Mrs. William L.....101 Allendale Pl.

W-Z

Walden, Mrs. Heinz J.....1622 Ohio St.
Weber, Mrs. Joseph.....2121 N. 11th St.
Weinbaum, Mrs. Jack G.....2705 Oak St.
Wheeler, Mrs. Byron C.....930 Indiana Ave.
White, Mrs. James V.....R. R. 1, Box 271
Wiedemann, Mrs. Frank E.....1530 S. Sixth St.
Wilson, Mrs. Fred L.....1124 S. Center St.
Wohlfeld, Mrs. Gerald.....203 Arcadia Dr.
Zwerner, Mrs. Paul F.....2510 N. Eighth St.

## WAYNE-UNION COUNTIES

Hill, Mrs. Paul G...5 N. Foote St., Cambridge City
Kenyon, Mrs. Emil..303 Mulberry, Cambridge City
Barton, Mrs. Willoughby M.
200 N. Morton, Centerville
Stepleton, Mrs. John D.....R. R. 2, Centerville
Shepard, Mrs. Fred F.....College Corner, Ohio
Hutchison, Mrs. Donald R.....Fountain City
Lewis, Mrs. J. Frank.....Liberty
McWilliams, Mrs. William B.....R. R. 4, Liberty
Clarkson, Mrs. Clarence G.....Liberty

**Richmond**

Adney, Mrs. Frank.....214 S. E. Parkway
Ake, Mrs. Loren.....220 S. 18th St.
Allen, Mrs. Robert T.....212 S. 21st St.
Anderson, Mrs. Robert C...Richmond State Hosp.
Ballenger, Mrs. William E.....3224 Berwyn Lane
Brooks, Mrs. G. Tanner.....29 S. 12th St.
Brown, Mrs. Richard J.....231 S. 15th St.
Buche, Mrs. Frederick P.....2408 S. "E" St.
Coble, Mrs. Frank H.....R. R. 3, Box 38
Cox, Mrs. Leon T.
10 Clifton Rd., Spring Grove Heights
Daggy, Mrs. B. T.....2500 S. "A" St.
Daggy, Mrs. James R.....2422 S. "D" St.
Dingle, Mrs. Paul E.....206 S. 32nd St.
Dreyer, Mrs. Ralph W.....410 S. W. "F" St.
Ebbinghouse, Mrs. Tom.....13 Parkway Lane
Gibson, Mrs. Alois E.....209 S. 16th St.
Griffis, Mrs. Vierl C.....201 S. 23rd St.
Guthrie, Mrs. James R.....3112 S. E. Parkway
Hance, Mrs. Darwood B.....3308 Glen Hills
Harmon, Mrs. Carl J.....6 Keystone, Apt. 6
Hill, Mrs. Harold D.....123 S. 23rd St.
Johnson, Mrs. George M.....115 S. 23rd St.
Kendall, Mrs. William R.....126 S. 24th St.
Kime, Mrs. Charles E.....501 S. 19th St.
Lee, Mrs. Glen Ward.....Greenmount Pike
Ling, Mrs. John F.....6 Parkway Lane
Logan, Mrs. James Z.....15 Parkway Lane
Loomis, Mrs. Charles H.....Garwood Rd.
McIlroy, Mrs. Richard J.....1912 E. Main St.
Mader, Mrs. John H.....1528 Chester Blvd.
Mahrt, Mrs. Delmar.....116 S. W. "J" St.
Malcolm, Mrs. Russell L...2630 Pleasant View Rd.
Meredith, Mrs. Elwood J.....200 S. 20th St.
Miller, Mrs. Harold L.....603 S. 23rd St.
Millis, Mrs. Arthur B.....2301 S. "A" St.
Park, Mrs. Byron J.....303 S. 23rd St.
Pentecost, Mrs. Paul S.....1300 Chester Blvd.
Plasterer, Mrs. Edward D.....212 S. 16th St.
Porter, Mrs. George S.....Spring Grove Heights
Ramsdell, Mrs. Glen A.....501 Henley Rd. S.
Ross, Mrs. Harry P.....220 S. 19th St.
Runge, Mrs. Paul W.....115 S. 17th St.
Sage, Mrs. Charles V.....416 S. 18th St.
Schmitt, Mrs. Robert W.....25 Circle Dr.
Sherer, Mrs. Kenneth E.....4 Parkway Lane
Shields, Mrs. Tom S.....2203 S. "E" St.
Snyder, Mrs. Morris C.....212 S. 22nd St.
Stilwell, Mrs. William R.....2607 S. "C" Pl.
Sweet, Mrs. Howard E.....Garwood Rd.
Wanninger, Mrs. Horace.....315 S. 15th St.
Warrick, Mrs. Francis B.....2106 South "B" St.
Weitemier, Mrs. Raymond A.....25 S. 25th St.
Wertenberger, Mrs. Morris.....Greenmount Pike
Wiland, Mrs. Olin K.....2603 S. "C" Pl.
Wynegar, Mrs. David E.....Richmond State Hosp.
Zore, Mrs. Joseph J.....2603 Reeveston Rd.

## WELLS COUNTY

**Bluffton**

Bixler, Mrs. James A...1020 Highland Park Circle
Boonstra, Mrs. Charles E.
1110 Highland Pk. Circle
Bradley, Mrs. Louis F.....504 W. South St.
Caylor, Mrs. Charles H.....1220 Sycamore Lane
Caylor, Mrs. Harold D.....411 W. Market St.
Caylor, Mrs. Truman E.....920 River Rd.
Collins, Mrs. Jack T.....R. R. 3
Cook, Mrs. Robert G.....1225 Summit Ave.
Dorrance, Mrs. Thomas O.....302 Northwood Dr.
Eisaman, Mrs. Jack L.....1011 Riverview Dr.
Huffman, Mrs. Galen.....1000 Summit Ave.
Jackson, Mrs. Charles E.....1012 Riverview Dr.
Kephart, Mrs. S. Bruce.....P. O. Box 12
Matzen, Mrs. Richard N.....121 E. South St.
Mayock, Mrs. Peter P.....225 W. Central Ave.
Meier, Mrs. Donald W.....1205 Summit Ave.
Panos, Mrs. Constantine G.....Elm Grove Road
Phillips, Mrs. John F.....411 W. Washington
Pietz, Mrs. David G.....322½ E. Central Ave.
Rusher, Mrs. Merrill W.....920 Ranch Rd.
Segmiller, Mrs. Wm. C.....820 Parkway Dr.
Smith, Mrs. H. Brooks.....333 Wayne St.
Sorg, Mrs. David.....734 Fort Wayne Rd.
Steckbeck, Mrs. Robert L.....627 McCoy Rd.
Stevens, Mrs. Adam C.....320 S. Main St.
Strehler, Mrs. Donald A.....R. R. 4
Symon, Mrs. William E.....632 S. Main St.
Talbert, Mrs. Pierre C.....508 W. Cherry St.
Yoder, Mrs. Richard P.....931 S. Wayne St.

## WHITE COUNTY

Derhammer, Mrs. George L.....Brookston
Houser, Mrs. Wayne.....Monon

**Monticello**

Beck, Mrs. David C.....R. R. 3
Carney, Mrs. John.....R. R. 2
Dickerson, Mrs. W. Martin....218 E. Market St.
Hibner, Mrs. Nolan A.....214 S. Illinois
Jehanyar, Mrs. M. Ali.....R. R. 5
McClure, Mrs. Stanley E.....R. R. 1
Morris, Mrs. Warren V.....R. R. 3
Peck, Mrs. Franklin B., Sr.....R. R. 1

---

Baynes, Mrs. Frank L.....Wolcott

## WHITLEY COUNTY

Minick, Mrs. Linus J.....N. Line St., Churubusco

**Columbia City**

Hamilton, Mrs. Thomas G.....R. R. 3
Heritier, Mrs. C. Jules.....5 Blue River Dr.
Langohr, Mrs. John L.....321 N. Main St.
Lehmberg, Mrs. Otto F. C.....706 West Park Dr.
Niccum, Mrs. Warren L.....Grove Park
Nolt, Mrs. Ernest V.....Westwood Park
Reid, Mrs. Donald B.....West Park Dr.
Roth, Mrs. James R.....323 N. Chauncey St.
Thompson, Mrs. Frank M.....526 E. Jefferson
Vogel, Mrs. John L.....Grove Park
Wait, Mrs. Jerome H.....R. R. 5
Wilson, Mrs. John S.....313 S. Chauncey St.

---

Stalter, Mrs. Gaylord W.....North Webster
Garber, Mrs. Paul A.
401 Columbia St., South Whitley
Huffman, Mrs. Verlin P.
701 State St., South Whitley

## MEMBERS-AT-LARGE

Artz, Mrs. Richard W.
606 Darling, Angola, Steuben
Beardsley, Mrs. Frank A.
751 E. South St., Frankfort, Clinton
Benz, Mrs. Jesse C.
Box 115, Marengo, Harrison-Crawford
Blessinger, Mrs. Louis H.
738 N. Capitol Ave., Corydon, Harrison-Crawford
Bogardus, Mrs. Carl R.
Kyana Farm, Austin, Scott
Burkhardt, Mrs. Boyd
328 N. West St., Tipton, Tipton
Cameron, Mrs. Don F.
313 E. Maumee, Angola, Steuben
Carlyle, Mrs. Ivan E.
P.O. Box 118, Michigantown, Clinton
Carneal, Mrs. Thomas E.
305 S. Market St., Winamac, Pulaski

Carter, Mrs. Jean V.
215 Green St., Tipton, Tipton
Childs, Mrs. Wallace E.
414 Broadway, Madison, Jefferson-Switzerland
Compton, Mrs. George L.
221 N. Independence, Tipton, Tipton
Compton, Mrs. R. L.
1867 Trevilian Way, Louisville 5, Ky.
Crain, Mrs. James W.
Williamsport, Fountain-Warren
Ericson, Mrs. Harold L.
Box 366, Windfall, Tipton
Farris, Mrs. John J.
2 Brettwood Dr., Washington, Daviess-Martin
Garvin, Mrs. Donald B.....R. R. 3, Brazil, Clay
Graves, Mrs. Noel S.
404 W. Main, Vevay, Jefferson-Switzerland
Hall, Mrs. Donald L.
R. R. 1, Petersburg, Pike
Hare, Mrs. Francis W.
705 W. Second St., Madison, Jefferson-Switzerland
Hathaway, Mrs. Clayton B.
410 N. Broadway, Butler, DeKalb
Hisrich, Mrs. Lloyd W.
6 Henry St., Batesville, Ripley
Hoffman, Mrs. Max N.
227 Elm Dr., Covington, Fountain-Warren
Hollenburg, Mrs. Edward L.
501 Huddleston Rd., Winamac, Pulaski
Humphrey, Mrs. E. M.
1005 Orchard Dr., Covington, Fountain-Warren
Jinnings, Mrs. Loren..807 S. Lee, Garrett, DeKalb
Kantzer, Mrs. Floyd B.
608 E. Keyser St., Garrett, DeKalb
Kincaid, Mrs. Raymond..R. R. #1, Tipton, Tipton
Lett, Mrs. E. Briscoe
502 W. 1st St., Loogootee, Daviess-Martin
Lynch, Mrs. Otis R...Marengo, Harrison-Crawford
Maris, Mrs. Lee J.
606 Brady St., Attica, Fountain-Warren
Mason, Mrs. Donald G.
401 E. Maumee, Angola, Steuben
Maurer, Mrs. Robert
1115 N. Meridian, Brazil, Clay
May, Mrs. George A.
226 Maywood Lane, Madison Jefferson-Switzerland
McClain, Mrs. Marvin L.
384 E. McClain, Scottsburg, Scott
McConnell, Mrs. William C.
512 N. Meridian, Sunman, Ripley
McKittrick, Mrs. Jack
No. 1 Green Acres, Washington, Daviess-Martin
Mehne, Mrs. Richard G.
503 N. Walnut, Brazil, Clay
Mount, Mrs. Mathias S.
340 W. Mechanic, Bloomfield, Greene
Omstead, Mrs. Milton
110 S. Sixth St., Petersburg, Pike
Pearson, Mrs. William E.
290 N. Wabash, Wabash, Wabash
Person, Mrs. Theodore C.
600 N. Main, Veedersburg, Fountain-Warren
Petrich, Mrs. P. R.
409 E. Washington, Attica, Fountain-Warren
Pratt, Mrs. Ralph M.
2325 Blackmore Pl., Madison, Jefferson-Switzerland
Rang, Mrs. Arthur A.
211 N. E. 9th St., Washington, Daviess-Martin
Row, Mrs. George S.
101 E. Jefferson St., Osgood, Ripley
Sabens, Mrs. James A.
69 Wardell, Scottsburg, Scott
Schrepferman, Mrs. Wayne
R. R. 2, Hamilton, Steuben
Scott, Mrs. Irvin H.
320 W. Washington, Sullivan, Sullivan
Seat, Mrs. Marshall H.
310 Hefron, Washington, Daviess-Martin
Seward, Mrs. George
201 W. Main St., North Manchester, Wabash
Sloan, Mrs. W. Keith..340 Bunton Lane, Madison Jefferson-Switzerland
Smith, Mrs. Lloyd H.
R. R. 2, Briarwood Add., N. Manchester, Wabash
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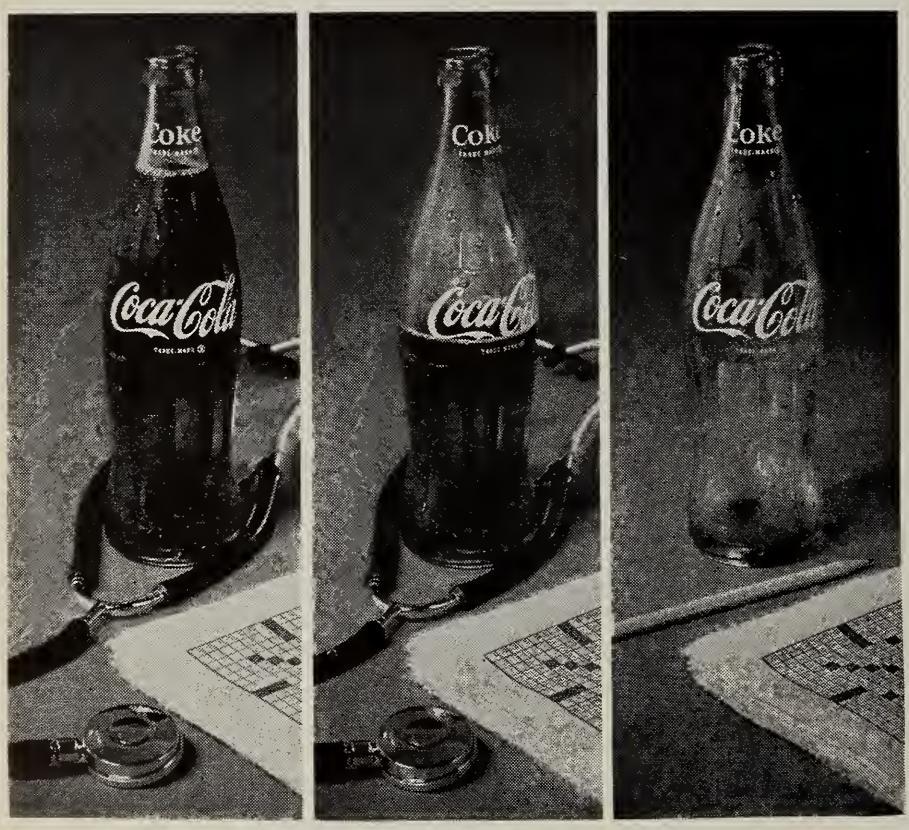
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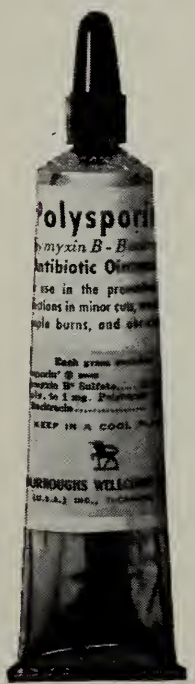
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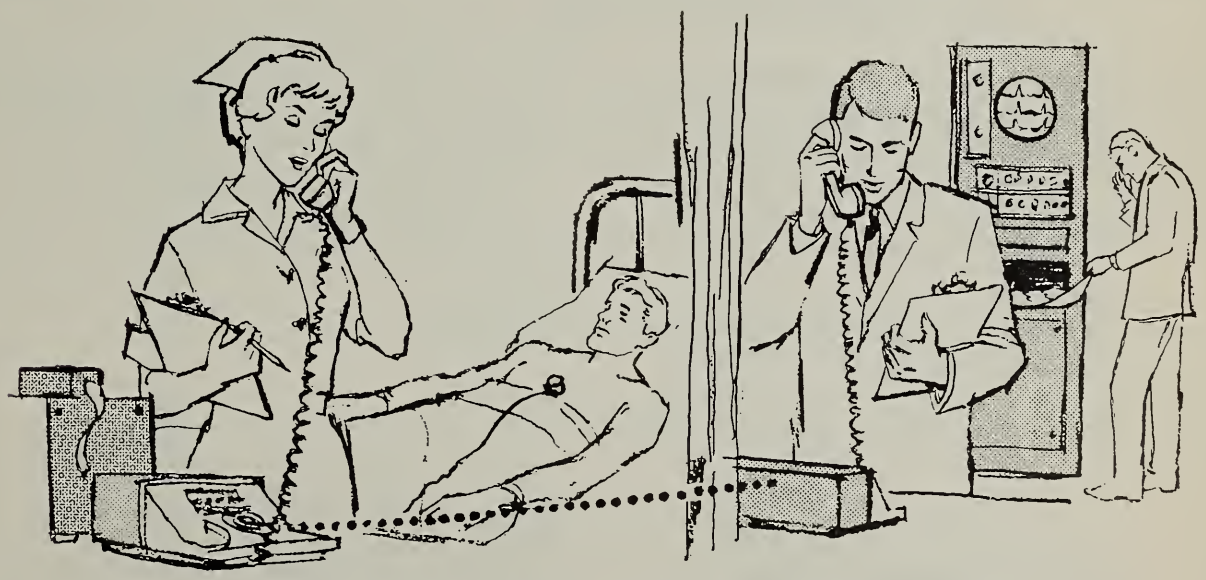
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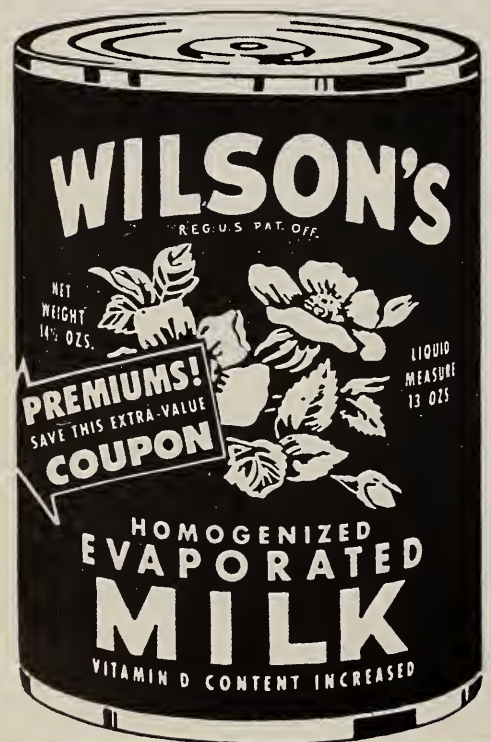
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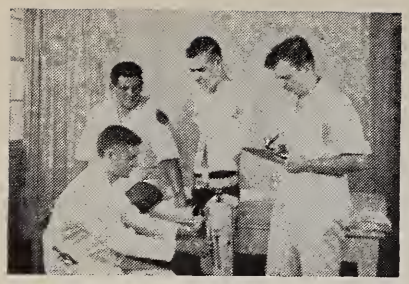
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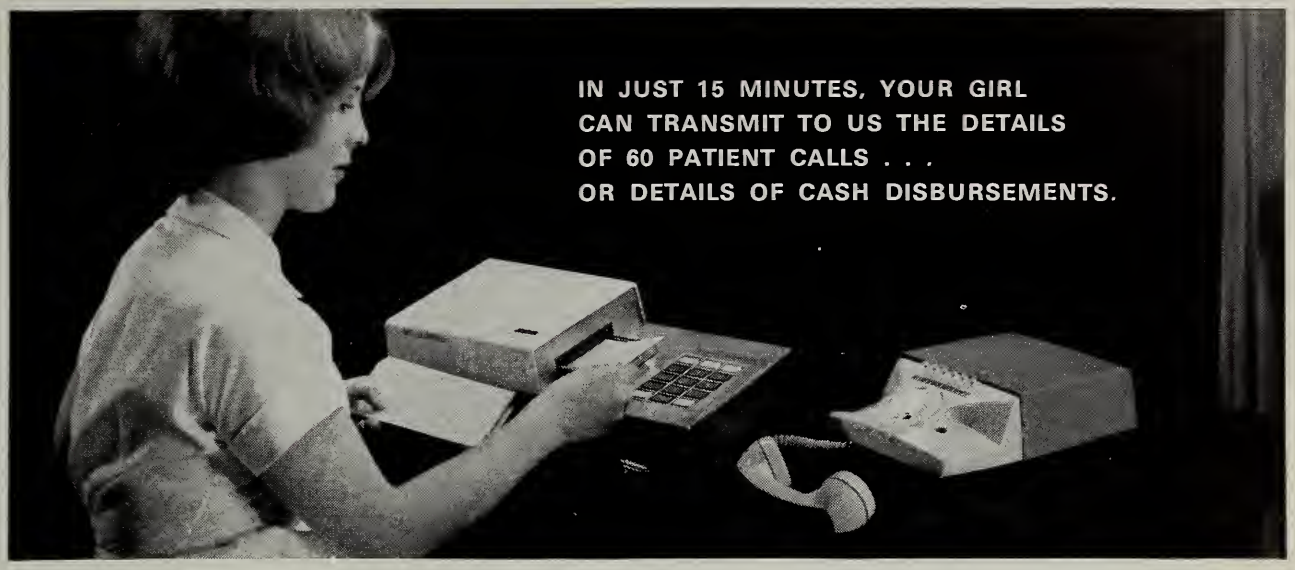
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**April, 1965**

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| Lutheran Hospital | Fort Wayne | Mrs. Carrie M. Filion, R.N. |
| Parkview-Methodist | Fort Wayne | Miss Marie Kolter, R.N. |
| St. Joseph's Hospital | Fort Wayne | Sister M. Theodorita, R.N. |
| X Methodist Hospital | Gary | Mrs. JoAnn Rowe, R.N. |
| St. Mary Mercy Hospital | Gary | Mrs. Mary Gulyassy, R.N. |
| St. Margaret Hospital | Hammond | Sister M. Huberta, R.N. |
| Marion County General Hospital | Indianapolis | Mrs. Thelma Richardson, R.N. |
| Methodist Hospital | Indianapolis | Miss Fredericka E. Koch, R.N. |
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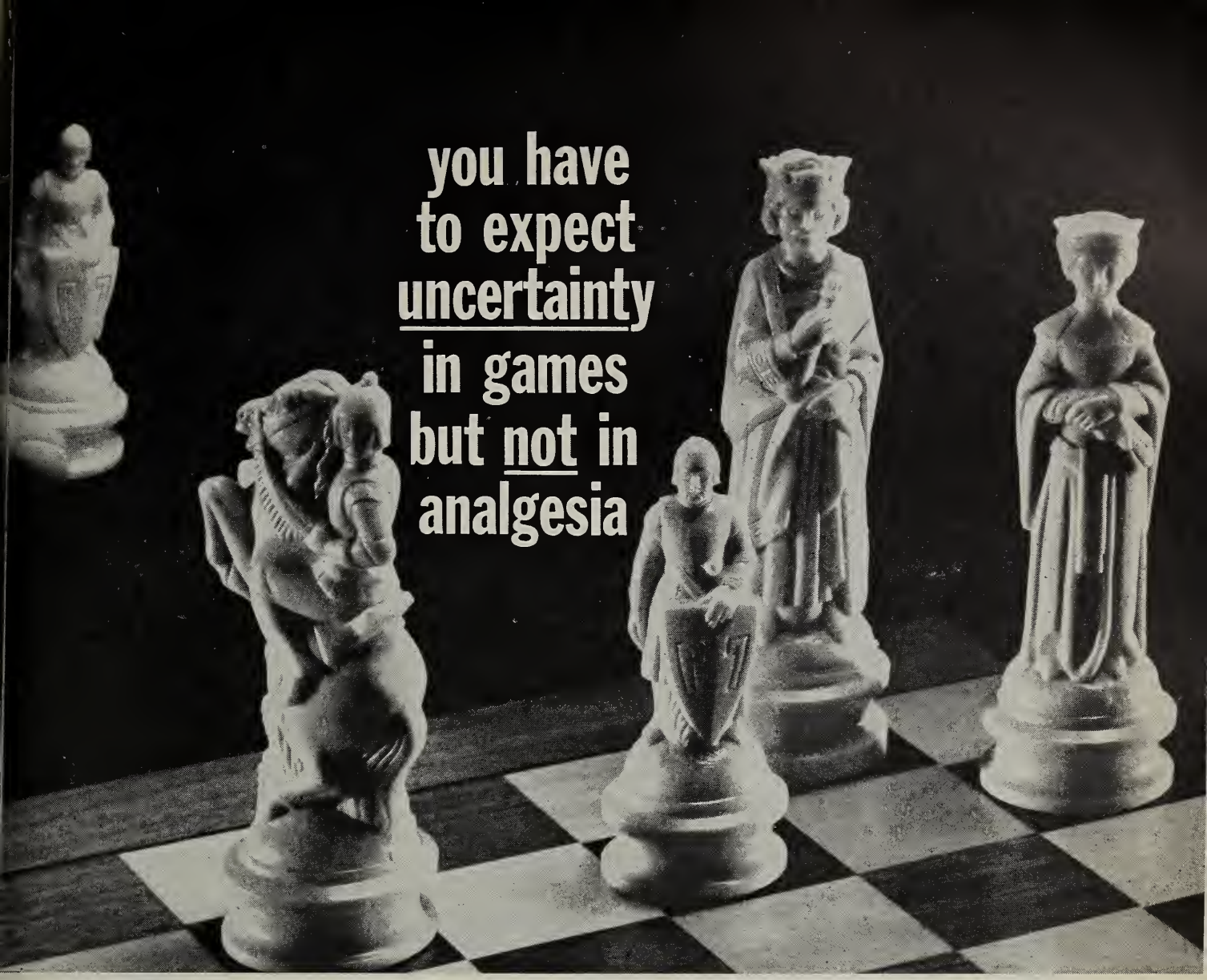
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| Goshen College | Goshen | Miss Orpah B. Mosemann, R.N., Director |
| DePauw University | Greencastle | Mrs. Catherine M. Firddle, R.N., Director |
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| Ball State University Dept. of Nursing | Muncie | Dr. Helen J. Berry, R.N., Head |
| Indiana State University | Terre Haute | Dr. Dorothy McMullan, R.N., Dean |

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|---|---|---|
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| Indiana Central College Dept. of Nursing | Indianapolis | Miss Virginia R. Sims, R.N., Director |
| * Indiana University Northwest Campus | Gary | Mrs. Dorothy Damewood, R.N., Coordinator |
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*Due to the additional content of the Yearbook, cut-off date for changes in the following groups was in April. Some have changed in the interim. However, it is felt that where officers have changed, a query to those listed here will put interested persons in contact with such groups.*

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* Dr. Appel will be installed at the June meeting of the AMA. The President-Elect had not been named at the time this issue went to press. His election will be announced in the July *Journal*.

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President—William M. Smith, M.D., South Bend.
President-Elect—William H. Mott, M.D., Gary.
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General Secretary—R. C. Henderson, M.D., Indianapolis.
Assistant Secretary—G. Tanner Brooks, M.D., Richmond.
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### INDIANA ASSOCIATION OF LICENSED NURSING HOMES

President—John R. Cooper, 306 W. Wabash Ave., Bluffton.
First Vice-President—Cora N. Anderson, L.P.N., R. R. 3, Box 306, Bluffton.
Second Vice-President—Ida Miller, 2301 Adams, Gary.
Recording Secretary—Martha E. Williams, Ben-Hur Home, Crawfordsville.
Treasurer—Emory H. Vollmer, 2630 N. College Ave., Indianapolis.
Attorney and Executive Secretary—Harry T. Latham, Jr., 900 Fletcher Trust Bldg., Indianapolis.
Governing Council Member to A.N.H.A.—Marjorie E. Pearsey, 114 E. 5th St., Rushville.

### INDIANA BOARD OF PHARMACY

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Secretary—Chase Derbyshire, Princeton.
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Executive Secretary—Joseph Schwartz, Indianapolis.
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Inspector—S. M. Wynkoop, Brookston.

### INDIANA HOSPITAL ASSOCIATION

President—Arthur S. Malasto, Administrator, Porter Memorial Hospital, Valparaiso.
President-Elect—Emery K. Zimmerman, Administrator, Elkhart General Hospital, Elkhart.
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Assistant Director and Director of Planning—Lionel G. Price, 27 E. 39th St., Indianapolis.

### INDIANA LEAGUE FOR NURSING, INC.

1126 N. Meridian St., Indianapolis 46204.

President—Miss Irma M. Bolte, 600 Edgar St., Evansville.
Secretary—Mrs. Jean T. Pontius, 4710 E. 71st St., Indianapolis.
Treasurer—Mr. John R. Mote, Methodist Hospital, Indianapolis.
Executive Secretary—E. Nancy Scramlin, 5460 E. 16th St., Indianapolis 46218.

### INDIANA OCCUPATIONAL THERAPY ASSOCIATION

President—Miss Dorothy Erickson, OTR, School of Occupational Therapy, I.U. Medical Center, Indianapolis.
Vice-President—Mrs. Carolyn Hendricks, OTR, Veterans Administration Hospital, 1481 W. 10th St., Indianapolis.
Treasurer—Miss Kathleen Heichelbech, OTR, Crossroads Rehabilitation Center, Indianapolis.
Secretary—Miss Nancy Griffin, OTR, School of Occupational Therapy, I.U. Medical Center, Indianapolis.
Delegate—Miss Margaret Smith, OTR, Crossroads Rehabilitation Center, Indianapolis.

### INDIANA PHARMACEUTICAL ASSOCIATION

54 Monument Circle, Indianapolis 46204.

President—Thurman H. Miller, Terre Haute.
Treasurer—Joseph B. Wade, Indianapolis.
Executive Secretary—James D. Hawkins, 54 Monument Circle, Indianapolis.

### INDIANA STATE LICENSED PRACTICAL NURSES' ASSOCIATION, INC.

President—Lucille Bryan, L.P.N., 230 E. Lincolnway, LaPorte.
First Vice-President—Alice Lucas, L.P.N., 1612 Hillcrest St., LaPorte.
Second Vice-President—Nannie Ransom, L.P.N., 2337 N. Rural St., Indianapolis.
Secretary—Esther Jones, L.P.N., 516 Lakeside St., LaPorte.
Treasurer—Cordelia Leeds, L.P.N., 6130 N. King St., Indianapolis.

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**President**—Malcolm McLelland, Division of Health and Physical Education, Indiana State Board of Health, 1330 West Michigan Street, Indianapolis.

**President-Elect**—Stanton Williamson, D.V.M., 217 West Chippewa Avenue, South Bend.

**Vice-President**—Gale E. Coons, Executive Secretary, Indiana State Dental Association, 721 Hume Mansur Building, Indianapolis.

**Secretary**—Helen L. Scheibner, Division of Health and Physical Education, Indiana State Board of Health, 1330 W. Michigan St., Indianapolis.

**Treasurer**—Seigel Osborn, Food Sanitation Section, Department of Public Health, Marion County Health & Hospital Corporation, City-County Building, Indianapolis.

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### INDIANA STATE DENTAL ASSOCIATION

721 Hume Mansur Bldg., Indianapolis 46204.

**President**—John E. Magnuson, D.D.S., LaPorte.

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**Vice-President**—Gorman F. McKean, D.D.S., Montpelier.

**Secretary**—Lloyd J. Phillips, D.D.S., Indianapolis.

**Treasurer**—Frederick A. Cantrell, D.D.S., Crawfordsville.

**Executive Secretary and Managing Editor**—Gale E. Coons, 721 Hume Mansur Bldg., Indianapolis 4.

### INDIANA STATE NURSES' ASSOCIATION

3231 N. Meridian St., Suite 63, Indianapolis 46208.

**President**—Mrs. Marie Loftus, R.N., Indianapolis.

**First Vice-President**—Jean Shockley, R.N., Indianapolis.

**Second Vice-President**—Mary Jo Freeman, R.N., Evansville.

**Secretary**—Dorothy E. Nentwig, R.N., Indianapolis.

**Treasurer**—Mrs. Mary Jean Haehl, R.N., Indianapolis.

**Executive Secretary**—Lucille Wall, R.N., 3231 N. Meridian St., Suite 63, Indianapolis.

**Asst. Executive Secretary**—Florence R. Brown, R.N., 3231 N. Meridian St., Suite 63, Indianapolis.

**Asst. Executive Secretary**—Mrs. Doris Baker, R.N., 3231 N. Meridian St., Suite 63, Indianapolis.

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# Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1965 annual meeting of the Indiana State Medi cal Association, Oct. 12-14 at Indianapolis, for a Physicians Art and Hobby Show

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

---

## Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

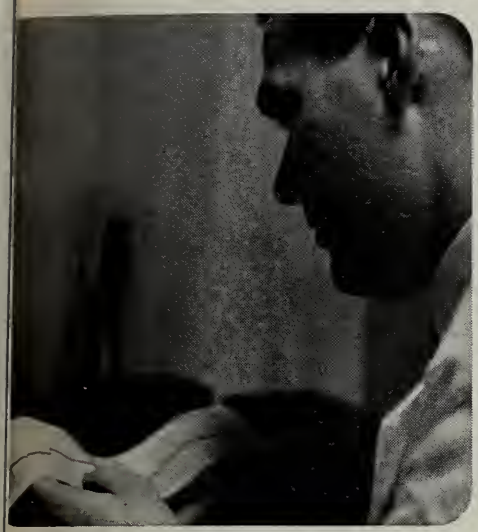
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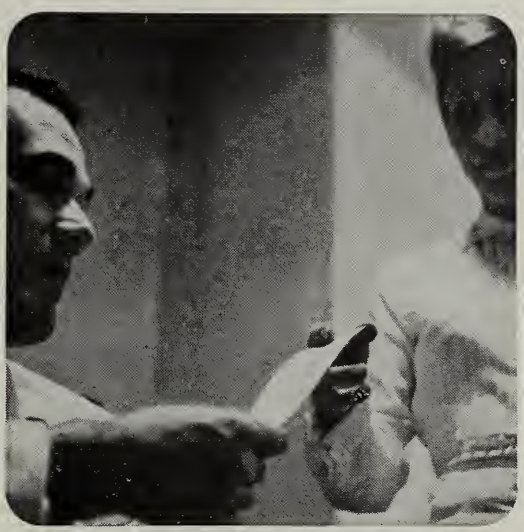
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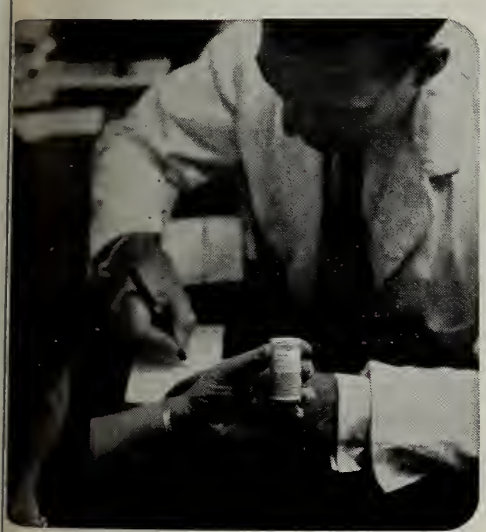




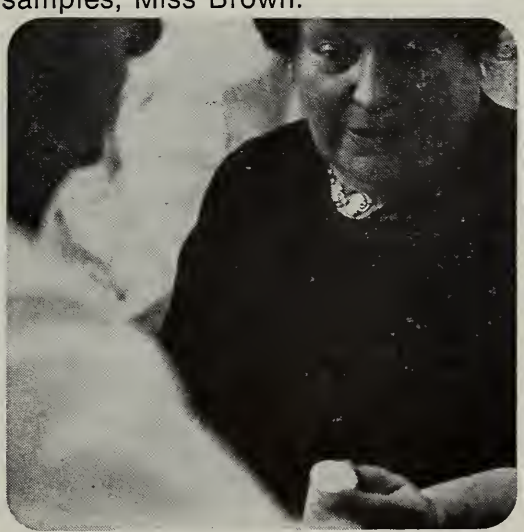
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*Side Effects:* Nausea, vomiting, diarrhea, muscle cramps, headaches and dizziness. Potential side effects include angina pectoris, anxiety, depression, drowsiness, hyperglycemia, hyperuricemia, lassitude, leukopenia, nasal stuffiness, nightmare, purpura, urticaria, and weakness.

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*Chupkovich, V.; Finnerty, F. A., Jr., and Kakaviatos, N.: The value of chlorthalidone plus reserpine in moderately severe and severe hypertension: A two year study. Presented at the 7th Inter-American Congress of Cardiology, Montreal, June 14–19, 1964.

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RE-3456

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—April, 1965

| Disease | Apr. 1965 | Mar. 1965 | Feb. 1965 | Apr. 1964 | Apr. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 738 | 608 | 329 | 904 | 890 |
| Chickenpox | 324 | 681 | 743 | 723 | 658 |
| Conjunctivitis | 70 | 155 | 116 | 207 | 87 |
| Diphtheria | 0 | 1 | 0 | 0 | 0 |
| Dysentery, Unspecified | 34 | 155 | 29 | 71 | 60 |
| Gonorrhea | 322 | 299 | 267 | 312 | Not Available |
| Impetigo | 48 | 130 | 100 | 146 | 64 |
| Infectious Hepatitis | 32 | 57 | 70 | 71 | 52 |
| Infectious Mononucleosis | 42 | 94 | 94 | 97 | 23 |
| Influenza | 652 | 5945 | 1301 | 506 | 959 |
| Measles (Rubeola-Rubella) | 523 | 755 | 320 | 6868 | 1176 |
| Meningitis, Meningococcal | 6 | 10 | 4 | 9 | 3 |
| Meningitis, Other | 7 | 11 | 9 | 9 | 9 |
| Mumps | 208 | 413 | 335 | 1422 | 370 |
| Pertussis | 13 | 7 | 32 | 53 | 13 |
| Pneumonia | 199 | 756 | 299 | 344 | 197 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 0 |
| Streptococcal Infection | 458 | 817 | 753 | 903 | 582 |
| Syphilis | | | | | |
| Primary & Secondary | 6 | 2 | 9 | 6 | Not Available |
| All Other Syphilis | 114 | 94 | 80 | 105 | Not Available |
| Tinea Capitis | 5 | 20 | 9 | 27 | 2 |
| Tuberculosis (Active) | 92 | 134 | 87 | 169 | 161 |

## ROSTER AND YEARBOOK ISSUES

This is the Roster and Yearbook issue of the Indiana State Medical Association. Included in the Roster are the names of all members of the ISMA listed alphabetically and by counties, plus the names of all the Woman's Auxiliary.

The Yearbook, besides carrying the Roster, includes listings of the following: State Health Organizations; Professional Medical and Allied Organizations; Voluntary Organizations; Heads of Departments at the I. U. School of Medicine; Indiana Accredited Practical Nursing Schools; Approved Hospitals in Indiana; Approved Mental Hospitals; Licensed Nursing Homes; Poison Control Centers in Indiana; Disease Prevention by Immunization and Chemoprophylaxis and Class A Narcotic Drugs.

If you would like to order either or both of these special issues, please check the appropriate box and send it along with your check or money order to *The Journal*, 3935 N. Meridian St., Indianapolis 8.

☐ Roster — $3.00

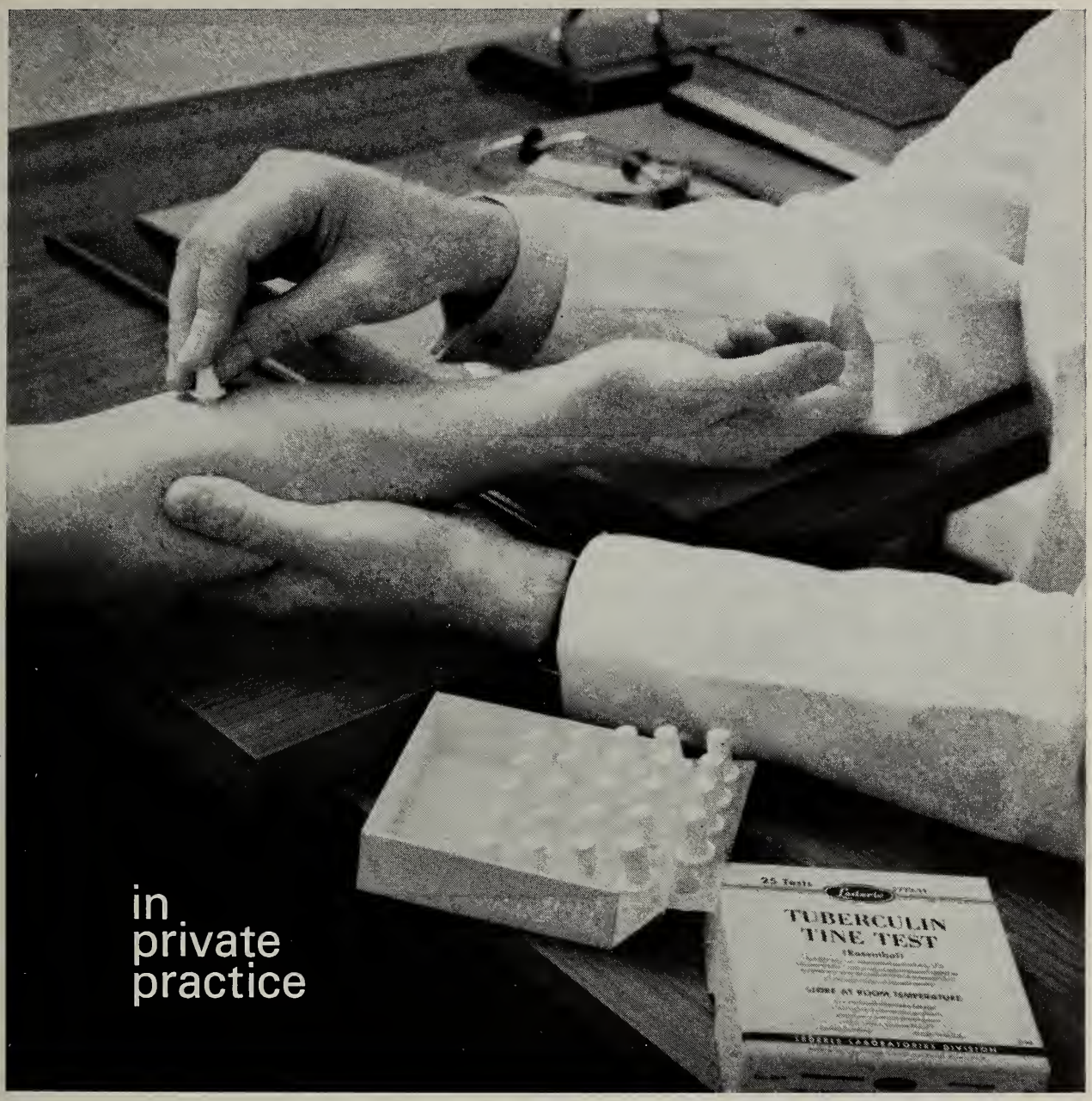
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State_____




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# Approved Hospitals in Indiana*

April 1, 1965

**ADAMS COUNTY**

**Adams County Memorial Hospital.**
804 Mercer Ave., Decatur.
Mr. Thurman I. Drew, Adm.

**ALLEN COUNTY**

**Parkview Memorial Hospital, Inc.**
2200 Randalia Dr., Fort Wayne.
Mr. Mark Slen, Adm.

**Irene Byron Hospital**
12515 Lima Rd., R.R. 13, Fort Wayne
O. T. Kidder, M.D., Adm. & Med. Dir.

**The Lutheran Hospital of Fort Wayne.**
3024 Fairfield Ave., Fort Wayne.
Mr. Edgar C. Kruse, Adm.

**St. Joseph's Hospital.**
730 W. Berry St., Fort Wayne.
Sister M. Odillia, Adm.

**BARTHOLOMEW COUNTY**

**Bartholomew County Hospital.**
2400 East 17th St., Columbus.
Miss Olive M. Murphy, R.N., Adm.

**BLACKFORD COUNTY**

**Blackford County Hospital.**
503 E. Van Cleve St., Hartford City.
Mrs. Mabel Brown, Adm.

**BOONE COUNTY**

**Witham Memorial Hospital.**
1124 N. Lebanon St., Lebanon.
Mr. John H. Luff, Adm.

**CASS COUNTY**

**Memorial Hospital.**
1101-1115 Michigan Ave., Logansport.
Mr. Herbert L. Fromm, Adm.

**St. Joseph Hospital.**
26th and North Sts., Logansport.
Sister M. Laurine, Adm.

**CLARK COUNTY**

**Clark County Memorial Hospital.**
210 Sparks Ave., Jeffersonville.
Mr. John C. Blankenbeckler, Adm.

**CLAY COUNTY**

**Clay County Hospital.**
1206 E. National Ave., Brazil.
Mrs. Madge Scobell, Act'g. Adm.

**CLINTON COUNTY**

**Clinton County Hospital.**
1300 S. Jackson St., Frankfort
Mr. William Russell, Adm.

**DAVIESS COUNTY**

**Daviess County Hospital.**
1310 Grand Ave., Washington.
Mr. Lawrence Trousdale, Adm.

**DEARBORN COUNTY**

**Dearborn County Hospital.**
600 Wilson Creek Rd., Lawrenceburg.
Mr. John H. Tallmadge, Adm.

**DECATUR COUNTY**

**Decatur County Memorial Hospital.**
720 N. Lincoln St., Greensburg.
Mr. William D. Gibson, Adm.

**DEKALB COUNTY**

**DeKalb Memorial Hospital, Inc.**
East Seventh St., Auburn.
Mr. R. O. King, Adm.

**Dr. Bonnell M. Souder Hospital, Inc.**
206 W. 7th St., Auburn.
Bonnell M. Souder, M.D., Adm.

**Garrett Community Hospital, Inc.**
220 S. Ijams St., Garrett.
Mr. Don Donley, Adm.

**DELAWARE COUNTY**

**Ball Memorial Hospital.**
2401 University Ave., Muncie.
Mr. Walter G. Ebert, Adm.

**DUBOIS COUNTY**

**Memorial Hospital of Dubois County.**
800 West 9th St., Jasper.
Mother M. Eugene, Adm.

**The Stork Memorial Hospital.**
530 4th St., Huntingburg.
Sister M. Johnita, Adm.

**ELKHART COUNTY**

**Elkhart General Hospital.**
600 East Boulevard, Elkhart.
Mr. Emery K. Zimmerman, Adm.

**Goshen General Hospital.**
200 High Park Avenue, Goshen.
Mr. Kenneth Swanson, Adm.

**FAYETTE COUNTY**

**Fayette Memorial Hospital.**
1941 Virginia Ave., Connersville.
Mr. Richards M. Manuel, Adm.

**FLOYD COUNTY**

**Memorial Hospital of Floyd County.**
1850 State St., New Albany.
Mr. William I. Fender, Jr., Adm.

**Southern Indiana Tuberculosis Hospital.**
New Albany.
Joseph H. Geyer, M.D., Adm.

**FULTON COUNTY**

**Woodlawn Hospital.**
624 Pontiac St., Rochester.
Mr. Edward Kucinski, Adm.

**GIBSON COUNTY**

**Gibson General Hospital.**
Sherman Drive, Princeton.
Mr. Herman A. Kohlman, Adm.

* Approved by the Indiana Council for Hospital Licensure and the Indiana State Board of Health.

### GRANT COUNTY

**Marion General Hospital.**
Wabash and Euclid, Marion.
Mr. John W. Green, Adm.

### GREENE COUNTY

**Freeman Greene County Hospital.**
410 "A" St., N.E., Linton.
Mr. Avery Murray, Adm.

### HAMILTON COUNTY

**Riverview Hospital.**
R.R. 4, Noblesville.
Mr. Peter R. Mariani, Adm.

### HANCOCK COUNTY

**Hancock County Memorial Hospital.**
800 North State Street, Greenfield.
Mr. C. L. Morris, Adm.

### HARRISON COUNTY

**Harrison County Hospital.**
R. R. 4, Box 33 H, Corydon.
Mr. John R. Webb, Adm.

### HENDRICKS COUNTY

**Hendricks County Hospital.**
1000 E. Main St., Danville.
Mr. Harry T. Haver, Jr., Adm.

### HENRY COUNTY

**Henry County Hospital.**
Rural St., New Castle.
Mr. Herbert A. Schacht, Adm.

### HOWARD COUNTY

**Howard Community Hospital.**
3500 S. LaFountain St., Kokomo.
Mr. Barry T. Bedenkop, Adm.

**St. Joseph Memorial Hospital.**
1907 W. Sycamore St., Kokomo.
Sister Ann Rita, Adm.

### HUNTINGTON COUNTY

**Huntington County Hospital.**
1215 Etna Ave., Huntington.
Mr. Carl S. Smyth, Adm.

### JACKSON COUNTY

**Jackson County Schneck Memorial Hospital.**
Bruce and Poplar St., Seymour.
Mr. Ralph W. Keyes, Adm.

### JASPER COUNTY

**Jasper County Hospital.**
216-224 S. Cullen St., Rensselaer.
Mrs. Ruth Schumaker, R.N., Adm.

### JAY COUNTY

**Jay County Hospital.**
505 W. Arch St., Portland.
Mr. Warren Phemister, Adm.

### JEFFERSON COUNTY

**The King's Daughters' Hospital.**
112 Presbyterian Ave., Madison.
Mr. W. A. McAlexander, Adm.

### JOHNSON COUNTY

**Indiana Masonic Home Hospital.**
690 State St., Franklin.
Mr. Roy Turner, Jr., Supt.

**Johnson County Memorial Hospital.**
R.R. 1, Franklin.
Mr. George P. Goshorn, Adm.

### KNOX COUNTY

**Good Samaritan Hospital.**
410 S. 7th St., Vincennes.
Mr. Stephen Collins, Adm.

**Hillcrest Tuberculosis Hospital.**
North 2nd St. Road, Vincennes.
J. Frank W. Stewart, M.D., Adm.

### KOSCIUSKO COUNTY

**Murphy Medical Center.**
101 W. Winona Ave., Warsaw.
Mrs. Hazel J. Murphy, Adm.

### LAGRANGE COUNTY

**LaGrange County Hospital.**
R.R. 1, LaGrange.
Miss Edythe L. Gappinger, R.N., Adm.

### LAKE COUNTY

**James O. Parramore Hospital.**
106 Road O, Crown Point.
Phillip H. Becker, M.D., Adm.

**The Methodist Hospital of Gary, Inc.**
1600 W. 6th Ave., Gary.
Mr. Everett A. Johnson, Adm.

**Our Lady of Mercy Hospital.**
U. S. Highway 30, Dyer.
Sister Mary Pierre, Adm.

**St. Catherine Hospital.**
4321 Fir St., East Chicago.
Sister M. Martine, Adm.

**St. Margaret Hospital.**
25 Douglas St., Hammond.
Sister M. Delphina, R.N., Adm.

**St. Mary Mercy Hospital.**
540 Tyler St., Gary.
Sister M. Cornelia, R.N., Adm.

### LAPORTE COUNTY

**Community Hospital of LaPorte, Inc.**
215 Pine Lake Ave., LaPorte.
Mr. L. H. Furlong, Adm.

**Holy Family Hospital.**
205 "E" St., LaPorte.
Sister M. Justine, Adm.

**Memorial Hospital of Michigan City Foundation, Inc.**
125 E. 5th St., Michigan City.
Mr. Byron N. Whitford, Dir.

**St. Anthony Hospital.**
Wabash and Ann Sts., Michigan City.
Sister M. Regis, Adm.

**Walters Hospital, Inc.**
719 Franklin St., Michigan City.
Mr. Robert Keller, Adm.

Continued

# APPROVED HOSPITALS

Continued

### LAWRENCE COUNTY

**Dunn Memorial Hospital.**
1616 23rd St., Bedford.
Mrs. Helen Boyer, R.N., Adm.

### MADISON COUNTY

**Community Hospital of Anderson and Madison County.**
1515 N. Madison Ave., Anderson.
Mr. Gordon S. Boughton, Adm.

**Mercy Hospital, Inc.**
1331 South "A" St., Elwood.
Sister M. Andrea, R.N., Adm.

**St. John's Hickey Memorial Hospital.**
127 W. 19th St., Anderson.
Sister M. Theodora, Adm.

### MARION COUNTY

**Community Hospital of Indianapolis, Inc.**
1500 N. Ritter Ave., Indianapolis.
Mr. W. C. McLin, Adm.

**Indiana University Medical Center Hospitals.**
1100 W. Michigan St., Indianapolis.
Mr. Elton T. Ridley, Act'g. Adm.

**Marion County Tuberculosis Hospital.**
960 Locke St., Indianapolis.
Arvine G. Popplewell, M.D., Supt. and Dir.

**Marion County General Hospital.**
Sunnyside Sanitorium, 6255 Sunnyside Road, Indianapolis.
John D. Miller, M.D., Adm. & Med. Dir.

**Memorial Clinic of Indianapolis.**
3202 N. Meridian St., Indianapolis.
Mr. Richard L. Albright, Adm.

**Methodist Hospital of Indiana, Inc.**
1604 N. Capitol Ave., Indianapolis.
Mr. Jack A. L. Hahn, Adm.

**St. Elizabeth's Maternity Hospital and Infant Home.**
2500 Churchman Ave., Indianapolis.
Rev. Donald Schmidlin, Adm.

**St. Francis Hospital.**
101 N. Seventeenth St., Beech Grove.
Sister Vincentiana, Adm.

**St. Vincent's Hospital.**
120 W. Fall Creek Parkway, Indianapolis.
Sister Mary Helen, Adm.

**University Heights Hospital, Inc.**
3350 Carson Ave., Indianapolis.
Mr. Donald L. Ciolli, Adm.

### MARSHALL COUNTY

**Community Hospital of German Township, Inc.**
411 W. Grant St., Bremen.
Mrs. Mary Harris, R.N., Adm.

**Parkview Hospital.**
1401 N. Michigan St., Plymouth.
Miss Lela Diefenbaugh, R.N., Adm.

### MIAMI COUNTY

**Dukes Memorial Hospital.**
275 West 12th St., Peru.
Mr. Jack G. Fougerousse, Adm.

### MONROE COUNTY

**Bloomington Hospital.**
640 S. Rogers St., Bloomington.
Mr. John H. Shephard, Adm.

### MONTGOMERY COUNTY

**Montgomery County Culver Union Hospital.**
308 Binford St., Crawfordsville.
Mr. Wm. R. Saunders, Adm.

### MORGAN COUNTY

**Comer-Kendrick Hospital, Inc.**
130 N. Indiana St., Mooresville.
William Kendrick, M.D., Adm.

**Morgan County Memorial Hospital.**
St. Rd. 252, Martinsville.
Mr. Ernest Baughman, Adm.

### NEWTON COUNTY

**George Ade Memorial Hospital.**
Brook, Ind.
Mr. Darryl Wahler, Adm.

### NOBLE COUNTY

**McCray Memorial Hospital.**
Hospital Dr., Kendallville.
Mr. Ronald N. Strand, Adm.

### ORANGE COUNTY

**Orange County Hospital.**
Sandy Hook Road, Paoli.
Miss Kathryn Landers, Adm.

### PARKE COUNTY

**Indiana State Hospital for Chest Diseases.**
R.R. 1, Rockville.
William D. May, M.D., Supt.

### PERRY COUNTY

**Perry County Memorial Hospital.**
Box 26, Tell City.
Mr. David Allen, Adm.

### PORTER COUNTY

**Porter Memorial Hospital.**
814 LaPorte Ave., Valparaiso.
Mr. Arthur S. Malasto, Adm.

### PULASKI COUNTY

**Pulaski Memorial Hospital.**
State Road 14, East, Winamac.
Mr. Benjamin L. Underwood, Adm.

### PUTNAM COUNTY

**Putnam County Hospital.**
330 Greenwood Ave., Greencastle.
Mr. James F. Shepherd, Adm.

### RANDOLPH COUNTY

**Randolph County Hospital.**
Oak Street, Winchester.
Mr. Harvey Norris, Adm.

**Union City Memorial Hospital Association.**
900 N. Columbia St., Union City.
Miss Kathryn E. Larrance, Adm.

### RIPLEY COUNTY

**Margaret Mary Hospital.**
Rosemont Division, Batesville.
Sister M. Theresa, Adm.

### RUSH COUNTY

**Rush Memorial Hospital.**
1300 N. Main St., Rushville.
Miss Nina Bosso, R.N., Adm.

### SCOTT COUNTY

**Scott County Memorial Hospital.**
Highway 31 North, Scottsburg.
Mrs. Margaret Collet, Act'g. Adm.

### SHELBY COUNTY

**William S. Major Hospital.**
150 W. Washington St., Shelbyville.
Mr. Roland E. Kohr, Adm.

### ST. JOSEPH COUNTY

**Healthwin Hospital.**
20531 West Darden Road, South Bend.
E. W. Custer, M.D., Adm.

**Memorial Hospital of South Bend.**
615 N. Michigan St., South Bend.
Mr. Richard W. Trenkner, Adm.

**St. Joseph Hospital.**
215 W. 4th St., Mishawaka.
Sister M. Maureen, Adm.

**St. Joseph Hospital of South Bend.**
811 E. Madison St., South Bend.
Sister M. Michaeleen, Adm.

**South Bend Osteopathic Hospital, Inc.**
2515 E. Jefferson Blvd., South Bend.
A. F. Kull, D.O., Adm.

### STARKE COUNTY

**Little Company of Mary Hospital and Home for Chronically Ill, Inc.**
Route 421, San Pierre.
Mother M. Catherine, Adm.

**Starke Memorial Hospital.**
102 Culver Road, Knox.
Mr. Lynn L. Landis, Adm.

### STEUBEN COUNTY

**Cameron Memorial Hospitals, Inc.**
416 E. Maumee, Angola.
Mrs. Harriet Angus, R.N., Adm.

**Elmhurst Hospital, Inc.**
909 W. Maumee, Angola.
Mr. T. Ray Alwood, Act'g. Adm.

### SULLIVAN COUNTY

**Mary Sherman Hospital.**
320 N. Section St., Sullivan.
Mr. William H. Sluder, Adm.

### TIPPECANOE COUNTY

**Lafayette Home Hospital, Inc.**
2400 E. South St., Lafayette.
Mr. Franklin E. Simek, Adm.

**Purdue University Student Health Center.**
Purdue University.
West Lafayette, Ind.
Loyal W. Combs, M.D., Adm.

**St. Elizabeth Hospital.**
1501 Hartford Street, Lafayette.
Sister M. Amelia, R.N., Adm.

### TIPTON COUNTY

**Tipton County Memorial Hospital.**
1032 South Main Street, Tipton.
Mr. James C. Talley, Adm.

### VANDERBURGH COUNTY

**Boehne Tuberculosis Hospital.**
Boehne Hospital Rd., Station B., Evansville.
Mr. Earle S. Wilks, Adm.

**Protestant Deaconess Hospital.**
600-700 Mary St., Evansville.
Mr. David A. Johnson, Adm.

**St. Mary's Hospital, Inc.**
3700 Washington Ave., Evansville.
Sister Mary James, Adm.

**Welborn Memorial Baptist Hospital, Inc.**
412 S.E. 4th St., Evansville.
Mr. Nolan R. Lackey, Adm.

### VERMILLION COUNTY

**Vermillion County Hospital.**
801 S. Main St., Clinton.
Miss Beulah Fisher, R.N., Adm.

### VIGO COUNTY

**St. Anthony Hospital.**
1021 S. 6th St., Terre Haute.
Sister M. Henrita, Adm.

**Union Hospital, Inc.**
1606 N. 7th St., Terre Haute.
Mr. Joseph B. Mackey, Adm.

### WABASH COUNTY

**Wabash County Hospital.**
670 N. East St., Wabash.
Mr. Richard G. Shedd, Adm.

### WARREN COUNTY

**Community Hospital.**
412 N. Monroe St., Williamsport.
Mr. George H. James, Jr., Adm.

### WASHINGTON COUNTY

**Washington County Memorial Hospital.**
911 N. Shelby Street, Salem.
Mr. Harry M. Voyles, Adm.

### WAYNE COUNTY

**Reid Memorial Hospital.**
Spring Grove, Richmond.
Mr. G. Dale Splitstone, Adm.

### WELLS COUNTY

**Clinic Hospital.**
309 S. Main St., Bluffton.
Mr. Ronald M. Adams, Adm.

**Wells County Hospital.**
1116 S. Main St., Bluffton.
Mrs. Dorothy Elett Radkey, R.N., Adm.

Continued

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**MEDICAL ASSOCIATION**

**October 12-14**

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## APPROVED HOSPITALS

Continued

**WHITE COUNTY**

**White County Memorial Hospital.**
Monticello.
Mr. George R. Banjak, Adm.

**WHITLEY COUNTY**

**Memorial Hospital.**
215 E. Van Buren St., Columbia City.
Mr. Carl F. Arntson, Adm.

**Whitley County Memorial Hospital.**
353 N. Oak St., Columbia City.
Mr. Stanley S. Mullendore, Adm.

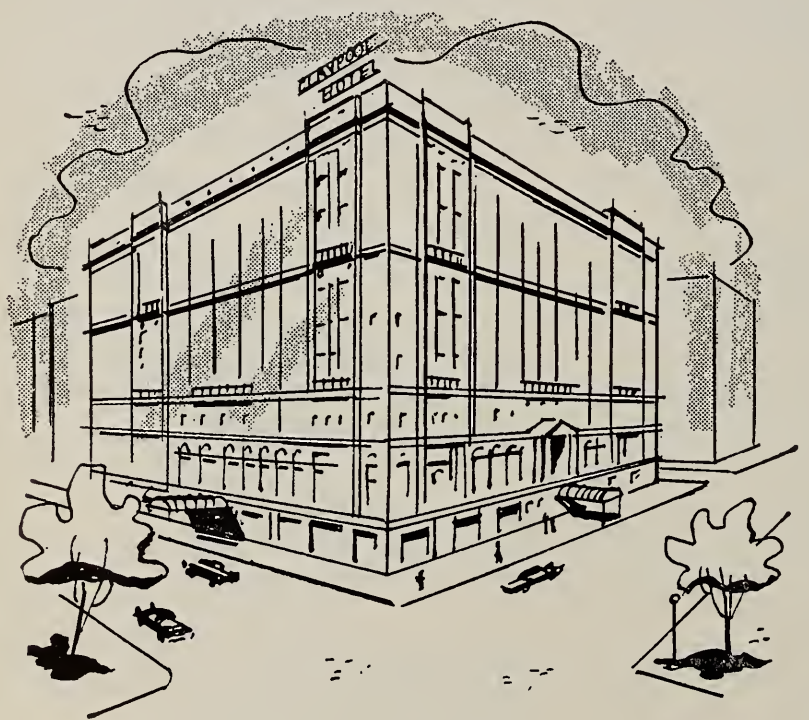
### *Approved Mental Hospitals in Indiana*

See State-Operated Mental Institutions, Page 620.

**Clearview Hospital.**
Kratzville Road, Evansville.
Mr. William J. Bulger, Adm.

**Ann Taylor Hospital.**
2231 Broadway, Indianapolis.
Mrs. Ann Long, Mrs. May Masters, Adms.

**Wabash Valley Sanitarium.**
Lafayette.
Mr. Donald R. Kinzer, Bus. Mgr. ◄



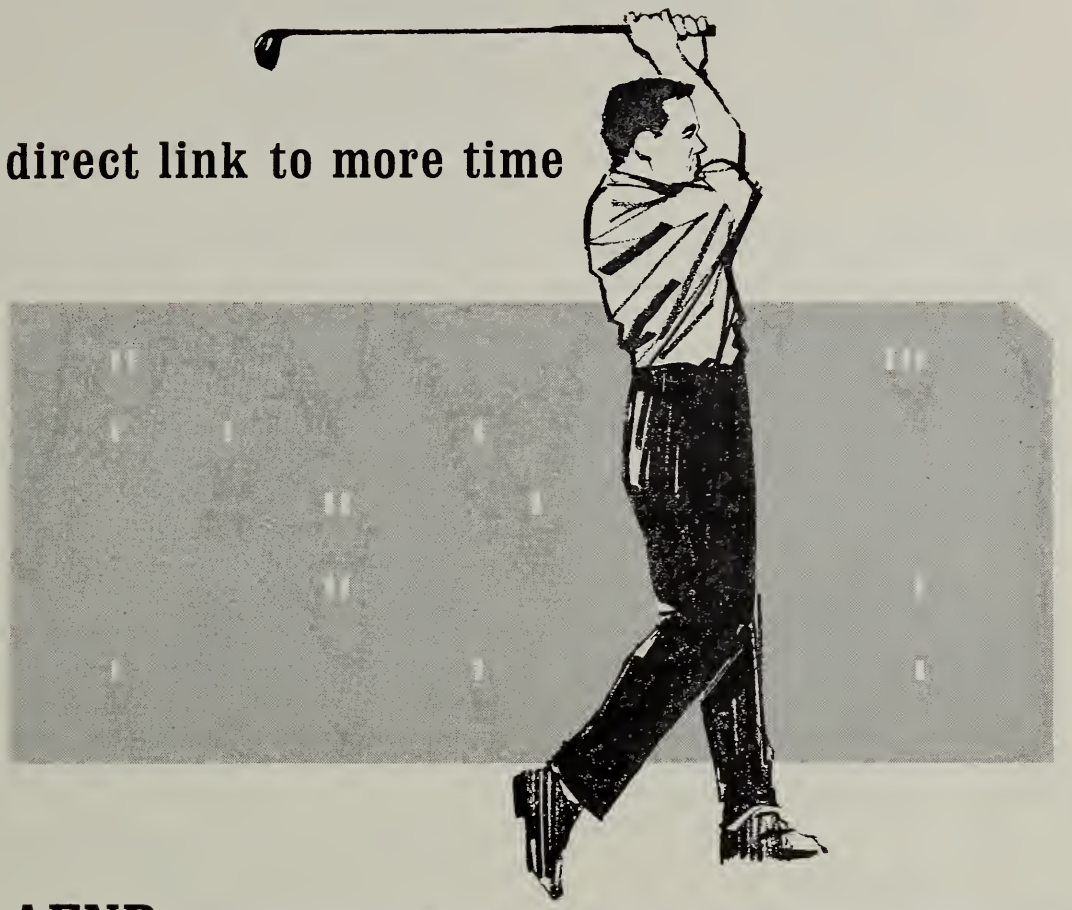

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# Outpatient Mental Health Facilities In The State of Indiana: 1965

BERNARD LUBIN, Ph.D.
ALBERT LINCH, M.S.W.
*Indiana Department of Mental Health*
*Indianapolis*

**Following is a list of outpatient mental health facilities in the state of Indiana, alphabetized by city of location. The reader who might be interested in additional services (family services, pastoral counseling, psychological testing and a more detailed listing of services, staff and application procedure) should consult the listing of June, 1964.†**

### Bloomington

Indiana University Psychological Clinic, Psychology Building. 332-0211.
Delton Beier, Ph.D., Director

### Columbus

*Bartholomew County Mental Health and Guidance Center, 1541 Hutchins Avenue. 372-7877.
George C. Weinland, M.D.
Medical Director

### Elkhart

*Adult and Child Guidance Clinic of Elkhart County, Inc., 224 W. High St. JA 2-4522.
John Keating, M.D., Medical Director

*Oaklawn Psychiatric Center, Inc., 2600 Oakland Avenue. JA 3-3350.
Otto Klassen, M.D., Medical Director
Robert Hartzler, Administrator

### Evansville

*Adult Psychiatric Clinic of Vanderburgh County, Inc., 516 Southeast 4th St. HA 5-4251.
John Longstaff, M.D.
Medical Director

*Vanderburgh Child Guidance Center, 1 North Barker Avenue. 424-8227.
Lillian Moulton, M.D.
Medical Director

### Fort Wayne

*Adult Psychiatric Center of Northeast Indiana, Inc., 227 East Washington Blvd. 743-5471, Ext. 215.
William C. Lyon, M.D.
Medical Director

*Fort Wayne Child Guidance Center, Inc., 227 East Washington Blvd. 743-5471.
Robert L. Greenlee, M.D.
Medical Director

### Gary

*Lake County Mental Health Clinic, 4801 West 5th Avenue. 949-9031.
Krystyna Sklenarz, M.D.
Medical Director
Mary E. Redfox, Administrative Assistant

**Northwest Indiana Alcoholism Clinic, 4938 West 5th Avenue. 949-4275.
Robert Turgi, M.D., Medical Director
Esther Ramsey, R.N., Administrator

### Indianapolis

Adult Psychiatry Outpatient Clinic, Indiana University Medical Center. ME 5-8431.
John E. Kooiker, M.D.
Medical Director

**Central Indiana Alcoholism Clinic, Bahr Treatment Building, 3000 West Washington Street. ME 9-5304.
Jerome V. Pace, M.D.
Medical Director
Daniel Crowe, Administrator

*Child Guidance Clinic of Marion County, Inc., 1949 East 11th St. ME 2-5381.
Edward C. Shipley, M.D.
Medical Director

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* Partially supported by the Indiana Department of Mental Health.

** Completely supported by the Indiana Department of Mental Health.

† Lubin, B., Linch, A.: Outpatient Mental Health Facilities in the State of Indiana: 1964, *JISMA* 57:523-530, 1964.

Episcopal Community Services, Inc., 1535-37 Central Avenue. ME 5-2538.
David L. Phillips, M.D., Medical Director
The Rev. Peter C. Moore, Executive Director

*James Whitcomb Riley Child Guidance Clinic, Riley Hospital, Indiana University Medical Center, 1100 W. Michigan St. ME 5-8431, Ext. 533.
Nancy Roeske, M.D., Medical Director

**Larue D. Carter Memorial Hospital — Outpatient Clinic, 1315 West 10th Street. ME 4-8401.
Joseph A. FitzGerald, M.D.
Medical Director

Neurology Clinic, Marion County General Hospital, 960 Locke St. ME 6-6331.
Wesley A. Kissel, M.D.
Medical Director

Pediatric Neurology Clinic, Riley Hospital, 1100 West Michigan St. ME 5-8431.
Arthur Drew, M.D., Medical Director

Psychiatry Clinic, Marion County General Hospital, 960 Locke St. ME 6-6331.
Wesley A. Kissel, M.D.
Medical Director

Veterans Administration Regional Office Mental Hygiene Clinic, 36 South Pennsylvania. ME 3-7000.
John W. Crawford, M.D.
Medical Director

**Jeffersonville**

*Southern Indiana Mental Health and Guidance Center, Inc., Route 3, Box 320 E. BU 2-3929.
Joseph Brill, M.D., Medical Director
Kenneth Shore, M.S.S.W., Executive Director

**Kokomo**

*Guidance Center of Howard County, Inc., 308 West Taylor Street. 452-5667.
John M. Hoyt, M.D., Medical Director
David Barnett, ACSW, Administrator

**Lafayette**

Purdue Psychological Clinic, Education Building, Purdue University, West Lafayette. 92-2754.
John M. Hadley, Ph.D., Director

*Tippecanoe County Mental Health Center, Inc., 2900 North River Road, West Lafayette. RI 3-9656.
Joe M. Martin, M.D.
Medical Director

**Logansport**

*Guidance Center, Inc., 406 Barnes Building. 6441.
Heracleo Matheu, M.D.
Medical Director

**Marion**

*Grant County Mental Health Clinic, 412 South Boots Street. NO 4-0631.
Larry Musselman, M.D., Medical Director
Mrs. Margaret Straight, ACSW, Administrative Director

**Michigan City**

*Adult and Child Guidance Clinic for LaPorte County, 701 Washington Street. TR 2-7279.
John M. Hoyt, M.D., Medical Director
James W. Lubs, ACSW, Administrator

**Richmond**

*Child Guidance Clinic of Wayne County, Inc., 54 South 15th Street. 2-6139.
Robert W. Schmitt, M.D., Medical Director.
Richard I. Borden, M.S.W., Acting Administrative Director

**South Bend**

*St. Joseph County Adult and Child Guidance Clinic, 527 West Colfax Avenue. 233-5123.
Harold G. Nichols, M.D.
Medical Director

**Terre Haute**

*Vigo County Adult and Child Guidance Center, 415 North 9th St. LI-6291.
Harold Wilson, ACSW, Administrator

**Valparaiso**

Porter County Guidance Clinic, Inc., 306½ Washington Street. HO 2-1909.
Myron E. Berkson, M.D.
Medical Director

**Warsaw**

*Four County Mental Health Clinic, Inc., 315 West Center St. 267-7074.
Frank D. Hogle, M.D., Medical Director
Raymond Clausman, Ph.D., Administrator ◄

# *Annual Meeting Dates of Professional Medical and Allied Organizations*

**AMERICAN MEDICAL ASSOCIATION CONVENTION**
Date June 20-24, 1965
Place New York, N. Y.

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date May 3-5, 1966
Place Fort Wayne

**BONE AND JOINT CLUB**
Date October 13
Place The Athenaeum, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 25-26, 1965
Place South Bend

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 12-14, 1965
Place Murat Temple, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

**INDIANA ORTHOPAEDIC SOCIETY**
Date June 25-26, 1965
Place Marott Hotel, Indianapolis

**INDIANA ROENTGEN SOCIETY**
Date October 12, 1965
Place The Athenaeum, Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville



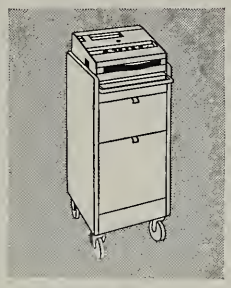


a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

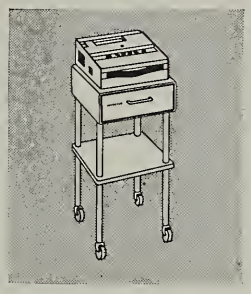
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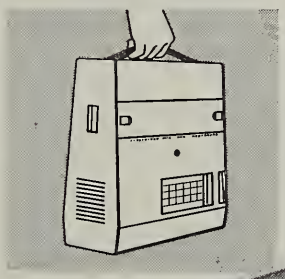
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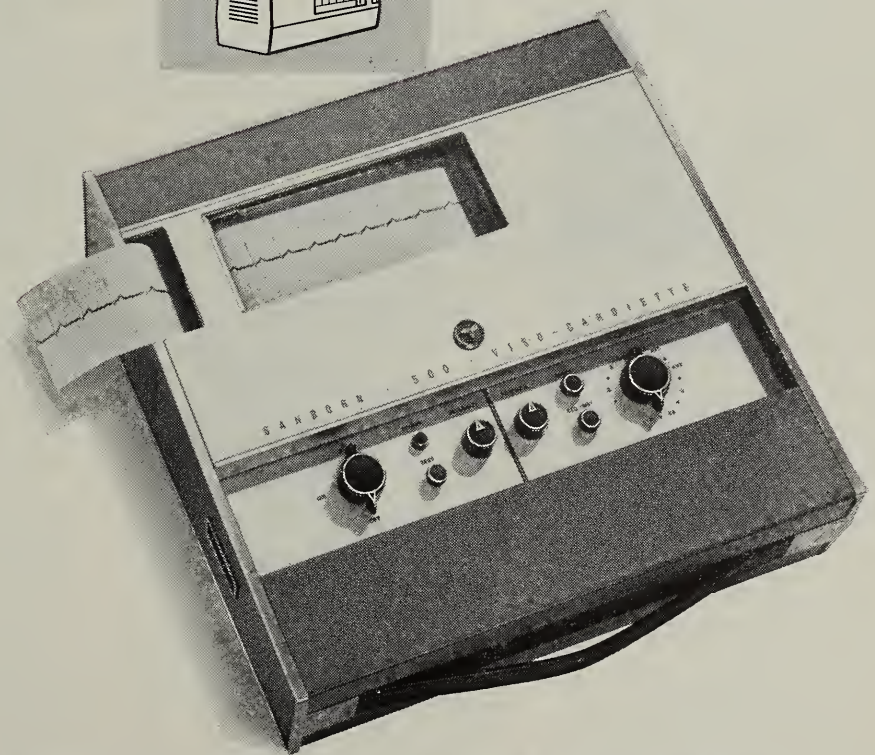
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# Licensed Nursing Homes In Indiana

May, 1965

### ADAMS COUNTY

**Berne Nursing Home**
906 W. Main St., Berne
Pauline Hostetler, L.P.N., Adm.

**Cooper Rest Home**
111 North Third St., Decatur
John R. and Janet E. Cooper, R.N., Adms.

### ALLEN COUNTY

**Allen County Home**
12101 Lima Rd., R. R. 13, Ft. Wayne
Orville E. Miller, Adm.

**Crow's Haven**
2440 Bowser Ave., Fort Wayne
Lyle B. Crow, Adm.

**East Creighton Nursing Home**
927 E. Creighton St., Ft. Wayne
Mary M. Poindexter, Adm.

**Fairfield Convalescent Home**
2520 Fairfield Ave., Ft. Wayne
John R. and Beatrice M. Morse, Adms.

**Glenacres, Inc.**
3420 E. State St., Fort Wayne
Ruby J. Setser, Adm.

**Grace Convalescent Home**
1529 California Ave., Ft. Wayne
Emma L. Meyer, Adm.

**Hope Manor**
611 W. Wayne St., Fort Wayne
Charles W. and Ruby J. Setser, Adms.

**Lawton Nursing Home, Inc.**
1649 Spy Run Ave., Fort Wayne
Walter C. Buuck, L.P.N., Adm.

**Parnell Park Nursing Home**
3811 Parnell Ave., Ft. Wayne
J. Leo Ash, Adm.

**Twin Maples Sanatarium**
734 W. Washington Blvd., Fort Wayne
Elizabeth Szegedy, Adm.

**West Berry Rest Home**
903 W. Berry, Fort Wayne
Charles W. and Ruby J. Setser, Adms.

### BARTHOLOMEW COUNTY

**Bartholomew County Home**
2525 Illinois, Columbus
Mildred Drake, Adm.

**Ken-Joy Convalescent Home**
Maple Street, Hope
Harold Chandler, Adm.

**Luther Nursing Home**
837 Fourth St., Columbus
Mary Luther, Adm.

**Pearl Gibson Boarding Home**
112 Washington St., Columbus
Pearl Gibson, Adm.

**Shady Nook Rest Home**
R. R. 8, Columbus
Louanna Niemoeller, Adm.

### BENTON COUNTY

**Benton County Home**
R. R. 1, Oxford
Kenneth Farney, Adm.

**Mary's Nursing Home**
Maple & Elm, Earl Park
Mary Belange, Adm.

### BLACKFORD COUNTY

**Blackford County County Home**
R. R. 1, Hartford City
Loren Conner, Adm.

**Jackson Nursing Home #1**
423 S. Main St., Montpelier
Rolland W. Jackson, Adm.

**Jackson Nursing Home #2**
110 E. Huntington St., Montpelier
Rolland W. Jackson, Adm.

**Waldo House**
511 W. Washington St., Hartford City
Martha Waldo, Adm.

### BOONE COUNTY

**Boone County Home**
R. R. 2, Lebanon
Marion D. Copeland, Adm.

**English Nursing Home**
1015 N. Lebanon, Lebanon
Bessie May English, Adm.

**Harris Nursing Home**
210 S. Pearl St., Thorntown
Maud Harris, Adm.

**Indiana Baptist Home, Inc.**
R. R. 1, Zionsville
Loren E. Moore, Adm.

**Maple Lawn Nursing Home**
195 N. Maple, Zionsville
Helena B. Davis, Adm.

**Red's Boarding Home**
1404 W. Camp, Lebanon
Mary R. Red, Adm.

**Smith Residential Home**
304 N. Lebanon St., Lebanon
Catharine Smith, Adm.

### CARROLL COUNTY

**The Brethren Home, Inc.**
R. F. D. 2, Box 97, Flora
Russell Kuns, Adm.

**Deer Creek Nursing Home**
R. R. 1, Camden
Mabel E. Bechdolt, Adm.

**Fix Community Home, Inc.**
404 S. Center St., Flora
Charles E. Fix, Adm.

**Fix Community Home, Inc., of Delphi**
321 E. Monroe, Delphi
Charles E. Fix, Adm.

**Good Will Nursing Home**
Main and Monroe Sts., Camden
Thomas and Mildred Shockley, Adms.

### CASS COUNTY

**Cass County Home**
Perrysburg Rd., Logansport
Oliver and Louise Mikesell, Adms.

**The Neal Home**
2518 George St., Logansport
Mrs. Carl B. Hamilton, Adm.

**Rest Haven Home**
731 North St., Logansport
Olive S. Jones, L.P.N., Adm.

### CLARK COUNTY

**Hillcrest Nursing Home, Inc.**
203 Sparks Ave., Jeffersonville
A. Lyle Havens, M.D., Adm.

**The Ladies Home, Inc.**
330 W. Market St., Jeffersonville
Anna Schimpff, Adm.

**Maple Court Nursing Home**
109 E. Maple Court, Clarksville
Goldie G. and Lola C. Hollingsworth, Adms.

**Twilight Nursing Home #1**
210 E. Maple St., Jeffersonville
Delilah Jean Goodwin, Adm.

**Twilight Nursing Home #3**
418 Riverside Dr., Jeffersonville
Delilah Jean Goodwin, Adm.

### CLAY COUNTY

**MaCanell Nursing Home**
R. R. 2, Box 139, Center Point
Hugh W. McCann, Adm.

**The Stinson Home**
601 S. Leavitt St., Brazil
Helen Stinson, Adm.

**Wilson Nursing Home**
525 E. Mechanic St., Brazil
Mary I. Wilson, Adm.

### CLINTON COUNTY

**Ashley Nursing & Convalescent Home**
R. R. 6, Frankfort
Francis J. and Jean A. Hladik, Adms.

**Bisel Nursing Home**
551 E. Walnut St., Frankfort
B. H. Bisel, Adm.

**Brock Nursing Home**
R. R. 4, Frankfort
Everett and Margaret Brock, Adms.

**Brown's Christian Nursing Home**
R. R. 1, Michigantown
Floyd Brown, Adm.

**Mulberry Lutheran Home, Inc.**
State Route 38, W. Jackson St., Mulberry
Rev. Russell Bussabarger, Adm.

**Newton Convalescent Home**
1201 E. Washington St., Frankfort
Westine Newton, R.N., Adm.

**Rice Nursing Home**
R. R. 1, Michigantown
Marie Rice, Adm.

**Shoemaker Memorial Home**
951 E. Clinton St., Frankfort
Rev. F. J. Goins, Adm.

**Summers Convalescent Home**
552 S. Columbia St., Frankfort
Florence B. Summers, Adm.

**Wesley Manor, Northwest Indiana Methodist Home, Inc.**
1555 N. Main St., Frankfort
Carlyle L. Mason, Adm.

### DAVIESS COUNTY

**Colvin Nursing Home**
1109 National Highway, Washington
Laura Colvin, Adm.

**Godwin Nursing Home**
819 Axtell Ave., Washington
Lelah Godwin, Adm.

**Meyers Nursing Home**
215 W. Oak St., Washington
Rosetta Meyers, Adm.

**Roby's Nursing Home**
101 Southside Ave., Washington
Thelma D. Roby, Adm.

### DEARBORN COUNTY

**Dillsboro Health Resort**
Box 66, Dillsboro
Dellas M. Ross, Adm.

**Shady Nook Convalescent Home**
607 Wilson Creek Rd., Lawrenceburg
Wilbur and Alta McMullen, Adms.

### DECATUR COUNTY

**Ada Schwind Nursing Home**
469 S. Monfort St., Greensburg
Ada Schwind, Adm.

**Jessup Nursing Home**
303 Jackson St., Greensburg
Margaret F. VanBriggle, Adm.

**Michigan Hill Nursing Home**
320 S. Michigan Ave., Greensburg
Barbara J. Mouser, Adm.

**Odd Fellows Home**
R. R. 8, Greensburg
William F. Hamilton, Adm.

**Paul-Ann Nursing Home**
R. R. 4, Greensburg
Paul E. and Ann Johnson, L.P.N., Adms.

**Ridout Nursing Home**
410 S. Broadway, Greensburg
Doris Wilson and Ruth Harrelson, Adms.

**Slone's Nursing Home**
515 W. Main St., Greensburg
Marie Slone, Adm.

### DEKALB COUNTY

**Barkley Nursing Home**
610 S. Broadway, Butler
Audrey E. Barkley, Adm.

**Betz Nursing Home**
R. R. 3, Auburn
Everett and Doris Betz, Adms.

**Butler Hotel Rest Home, Inc.**
117 S. Broadway St., Butler
Dorothy Dickerhoof, Adm.

**Garrett Convalescent Home**
611 S. Peters St., Garrett
Carlson and Mary Platz, Adms.

**Sheehy Nursing Homes, Inc.**
402 N. Broadway St., Butler
Flo Sheehy, Adm.

**Southview Nursing Home**
131 W. Depot St., Butler
Marjorie Harrold, Adm.

### DELAWARE COUNTY

**Bethel Nursing Home**
R. R. 7, Muncie
Emogene E. Turner, Adm.

**Chrystal's Country Home**
R. R. 1, Selma
Chrystal V. Steele, L.P.N., Adm.

**Delaware County Home**
R. R. 5, Muncie
William M. Lillie, Adm.

**Eads Nursing Home**
R. R. 7, Muncie
Epsy W. Eads, Adm.

**Faulkner Rest Home**
905 S. Grant St., Muncie
Edgar Faulkner, Adm.

**Frazee Convalescent Home**
R. R. 2, Dunkirk
Leatha Frazee, Adm.

**Golden Rule Nursing Home**
502 N. Madison St., Gaston
Eunice A. Messersmith, L.P.N., Adm.

**Maple Grove Convalescent Home**
1347 East Jackson St., Muncie
Pearl B. Harty, Adm.

**Morgan-Nickols Convalescent Home**
727 Wheeling Ave., Muncie
Margaret L. Nickols, Adm.

**Morgan-Nickols Residential Club**
175 Kilgore, Muncie
Margaret L. Nickols, Adm.

**Riverview Convalescent Home**
R. R. 2, Burlington Dr., Muncie
Nila M. Harty, Adm.

**Shady Haven Rest Home**
R. R. 6, Bethel Pike, Muncie
Leila C. Wilcox, Adm.

**Sylvester Home for the Aged**
R. R. 5, Burlington Dr., Muncie
Mantha J. Sylvester, Adm.

**Woodland Home #1**
917 E. Main St., Muncie
Hazel Wilson, R.N., Adm.

**Woodland Home #2**
1612 W. Jackson, Muncie
Hazel Wilson, R.N., Adm.

### DUBOIS COUNTY

**Hubster's Boarding Home**
1008 Van Buren, Huntingburg
Lillian Hubster, Adm.

**Indiana Rest Home**
115 E. Fifth St., Jasper
Matilda Sauter, Adm.

**Jasper Nursing Home**
102 W. Seventh St., Jasper
Lola M. Wehrle, Adm.

**Providence Home**
W. Ninth Street, Jasper
Rev. Philip Ottavi, Adm.

**St. Ann Nursing Home**
511 Fourth St., Huntingburg
Sister M. Josepha, R.N., Adm.

### ELKHART COUNTY

**The Austin Home**
526 N. Sixth St., Goshen
Hazel M. Neibert, Adm.

Continued

# NURSING HOMES

Continued

**Gay Peterson Nursing Home**
302 E. Lincoln Ave., Goshen
Iva Gay Peterson, Adm.

**Hutchinson Nursing Home**
302 S. Sixth St., Goshen
Irene Hutchinson, Adm.

**Ideal Rest Home**
925 Monroe St., Elkhart
Bonnie Sills, Adm.

**Lu-Ann Nursing Home**
952 W. Walnut St., Nappanee
Lucille Sechrist, R.N., Adm.

**Milleman Convalescent Home, Inc.**
430 W. Marion St., Elkhart
Herold A. and Hazel Milleman, Adms.

**Nicholson Convalescent Home**
2400 Elkhart Rd., Goshen
George and Gracia Nicholson, R.N., Adms.

**Rest Haven Nursing Home**
803 Wolf Ave., Elkhart
Elizabeth Calabrese, Adm.

**Rest Home**
525 W. Lexington Ave., Elkhart
Pearl Carr, Adm.

**Riley Convalescent Home**
527 S. Main St., Goshen
Albert and Eunice Riley, L.P.N., Adms.

**Simpson Nursing Home**
114 S. Sixth St., Goshen
Richard A. Simpson, Adm.

**Thorp Nursing Home**
621 E. Vistula St., Bristol
Ruth G. Thorp, Adm.

**Treva's Nursing Home**
1005 S. Third St., Elkhart
Treva M. Criss, Adm.

**Welcome Home**
1429 Krau, Elkhart
Josephine Ellsworth and Dorothy Metz, Adms.

**Wilson Nursing Home**
901 S. Second St., Elkhart
Neva B. Wilson, L.P.N., Adm.

### FAYETTE COUNTY

**Lincoln Manor Nursing Home**
903 Lincoln Ave., Connersville
Chester C. O'Neal, Adm.

**Paula-Mar Nursing Home**
319-21 Western Ave., Connersville
Paul E. and Mary M. Harvey, Adms.

### FLOYD COUNTY

**Providence Retirement Home**
703 E. Spring St., New Albany
Sister Catherine Loretta, Adm.

**Turley's Nursing Home**
1003 E. Main St., New Albany
Anna C. Turley, Adm.

### FOUNTAIN COUNTY

**Alward Nursing Home**
605 Summit St., Attica
Leston and Imogene B. Alward, R.N., Adms.

**Rudisill Nursing & Convalescent Home**
303 Second St., Covington
Susie M. Goff, Adm.

### FRANKLIN COUNTY

**Echo Hill Nursing Home**
R. R. 2, Laurel
Myrtle Jackson, Adm.

**Elsie Dreyer Nursing Home**
273 Main St., Brookville
Elsie Dreyer, Adm.

### FULTON COUNTY

**Fulton County Home**
R. R. 1, Rochester
Harley Thompson, Adm.

**Miller Nursing Home**
719 Madison St., Rochester
Helen Miller, Adm.

**Pontius Nursing Home**
426 Jefferson St., Rochester
Pearl Pontius, Adm.

**Rochester Nursing Home**
1118 Main St., Rochester
Gerald L. Eastburg, Adm.

### GIBSON COUNTY

**Colonial Nursing Home**
314 N. West St., Princeton
Bessie G. Mitchell, Adm.

**Duncan Wee Bonnie Rest Home**
R. R. 1, Princeton
Semira D. Fishman, Adm.

**Good Samaritan Home Inc., For Senior Citizens**
210 N. Gibson Rd., Oakland City
Buthyl and Roxie G. Hedges, Adms.

**Hottel Nursing Home**
East Main St., Francisco
Lillian A. Hottel, Adm.

**King's Boarding Home**
600 Strain St., Fort Branch
Bessie G. King, Adm.

**Maxey Nursing Home**
Main St., Box 53, Haubstadt
James and Mildred Maxey, Adms.

**Oakland City Rest Home**
114 Grove St., Oakland City
Otto Blubaum, Adm.

**Shady Grove Nursing Home**
Francisco
Roy and Ruth Morris, Adms.

### GRANT COUNTY

**Calbert's Rest Home**
204 N. Washington St., Marion
Wanda Whitaker, Adm.

**Ellen Hill Home, Inc.**
710 W. Third St., Marion
Opal E. Calbert, Adm.

**Emily E. Flinn Home, Inc.**
615 W. 12th St., Marion
Rev. James M. Hull, Adm.

**Golden Age Nursing Home**
1800 Kem Rd., Marion
Bernie Winkle, Adm.

**Jones Convalescent Home, Inc.**
518 W. 36th St., Marion
Carroll M. Jones, Adm.

**Jones Nursing Home**
P. O. Box 102, Fowlerton
Carroll Jones and Betty Jones, L.P.N., Adms.

**River-View Nursing Home, Inc.**
221 N. Washington, Marion
Ronald Brown, Adm.

### GREENE COUNTY

**Glenburn Rest Haven**
Glenburn Rd., R. R. 2, Linton
Nola D. Yoder, Adm.

### HAMILTON COUNTY

**Arcadia Rest Home**
405 S. East St., Arcadia
Florence Sigler, Adm.

**Hamilton Rest Home**
15755 Allisonville Rd., Noblesville
Mary E. McKinley, Adm.

**Lakeview Guest Home**
R. R. 1, Box 15, Carmel
Sara Wells, Adm.

**Sunderman Nursing Home**
69 N. Harrison St., Cicero
Bernard and Belva Sunderman, Adms.

### HANCOCK COUNTY

**Pleasant Acres**
R. R. 12, Box 320, Indianapolis
Frederick M. and Lorna Burns, L.P.N., Adms.

**Twinbrook, Inc.**
R. R. 4, Box 66, Greenfield
James L. Kavalaris, Adm.

**Wood Nursing Home**
14 N. Wood St., Greenfield
Hazel E. Wood, L.P.N., Adm.

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When a tranquilizer is needed, 'Stelazine' can regulate the level of anxiety so that the patient is unlikely to overreact to stress but is not tranquilized into psychic inertia. Patients on 'Stelazine' often experience a sense of mental alertness and, because they feel so much better, are more interested in their normal activities.

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# NURSING HOMES

Continued

### HARRISON COUNTY

**The Capitol Rest Home**
408 N. Capitol Ave., Corydon
John E. Mathes, Adm.

### HENDRICKS COUNTY

**Danville Nursing Home**
64 N. High St., Danville
Pearl Perkins, Adm.

**Golden Rule Nursing Home**
147 S. Wayne St., Danville
Robert and Ethel Petree, Adms.

**Vinewood Nursing Home**
404 North Vine St., Plainfield
Stephen Snyder and Carolyn Sue Warner, R.N., Adms.

### HENRY COUNTY

**"The Boxwoods" Nursing Home**
115 N. 10th St., New Castle
Paul and Carlisle Butcher, Adms.

**Hammond Nursing Home**
806 W. Broad St., New Castle
Betty I. Hammond, L.P.N., Adm.

**Henry County Home**
N. Memorial Dr., New Castle
Walter K. Gaddis, Adm.

**Lewisville Hotel for Senior Citizens**
U. S. 40, Lewisville
Bruce and Sarah Jones, Adms.

**Middletown Nursing Home**
130 S. 10th St., Middletown
Robert I. Clevenger, Adm.

**New Hope Nursing Home**
Lewisville
Mildred King, Adm.

**Rest Haven**
420 S. Main St., New Castle
Dorothy Shipp, R.N., Adm.

**Ryse Boarding Home**
R. R. 5, New Castle
John T. and Arizonia Ryse, Adms.

### HOWARD COUNTY

**Harrell's Boarding House**
708 N. Main St., Kokomo
June Harrell, Adm.

**Hillcrest Nursing Home**
1210 E. Jefferson St., Kokomo
Sarah Naomi Miller, Adm.

**Kokomo Convalescent Center**
429 Lincoln Rd. W., Kokomo
Donald L. Meyer, Adm.

**Lucy Cole Nursing Home**
332 W. Markland, Kokomo
Lucy Cole, L.P.N., Adm.

**Pleasant Rest**
508 W. Taylor St., Kokomo
Homer E. and Frances T. Johnson, Adms.

**Samaritan Home of Kokomo, Inc.**
513 East Vaile Ave., Kokomo
Sister Raphael, Adm.

**Villa Marie Home**
3810 W. Jefferson, Kokomo
Sister M. Seraphine, Adm.

### HUNTINGTON COUNTY

**Huntington County Home**
R. R. 5, Huntington
Harry A. Smith, Adm.

**Methodist Memorial Home for the Aged, Inc.**
Warren
Dr. Dewey C. Souder, Adm.

**Roanoke Nursing Home, Inc.**
743 N. Main Street, Roanoke
Robert and Joyce Barna, Adms.

**Town & County Nursing Home**
Goshen Rd., Huntington
Donald E. and Marlene Barna, R. N., Adms.

### JACKSON COUNTY

**Rose Lawn Annex**
305 St. Louis Ave., Seymour
Esta T. Martin, Adm.

**Rose Lawn Nursing Home**
202 W. Sixth St., Seymour
Marcia Kaley, Adm.

**West Side Nursing Home**
108 S. Pine St., Seymour
Jennie West and Harriette Rebholz, Adms.

### JASPER COUNTY

**Jasper County Home**
R. R. 3, Rensselaer
Fred Hall, Adm.

**Remington Rest Home**
Illinois and Minnesota Sts., Remington
Birdella N. Sullivan, Adm.

### JAY COUNTY

**Portland Nursing Home, Inc.**
406 W. Arch St., Portland
Mary Ellen Hearn, Adm.

### JEFFERSON COUNTY

**Hanover Nursing Home**
S. R. 56 W., Hanover
Ella L. Shuell, R.N., Adm.

**Willmann Rest Home**
620 Green Rd., Madison
Clifford and Lorene Willmann, Adms.

### JENNINGS COUNTY

**Johnson's Convalescent Home**
113 E. Jackson, North Vernon
Gladys Johnson, Adm.

### JOHNSON COUNTY

**Faith Home**
P. O. Box 65, Edinburg
Raymond C. Brown, Adm.

**Greenwood Hilltop Nursing Home**
R. R. 2, Fry Rd., Greenwood
Violet Van Sickle, Adm.

**Hardin's Nursing Home**
400 Kentucky St., Franklin
James S. and Bertha L. Hardin, Adms.

**Indiana Masonic Home**
Franklin
Roy O. Turner, Adm.

**Indiana Retired Teacher's Community**
Greenwood Village, Greenwood
Virginia Hunter, Adm.

**Janie's Nursing Home**
651 S. State St., Franklin
Janie Johnson, L.P.N., Adm.

**Johnson County Home**
R. R. 1-B, Franklin
Albert Bundy, Adm.

**Methodist Home**
Franklin
Rev. W. D. Koehnlein, Adm.

**Mickie's Nursing Home**
750 W. Madison, Franklin
Mildred Harris, Adm.

**The Welcome Nursing Home**
1109 N. Main St., Franklin
Stephen J. Snyder, Adm.

### KNOX COUNTY

**Freelandville Community Home, Inc.**
Freelandville
Lorena Walters, R.N., Adm.

**Ideal Nursing Home**
402 Broadway, Vincennes
Cora Thornberry Joyce, Adm.

**Moore's Nursing Home**
204 W. Third St., Bicknell
Ernest P. and Barbara J. Moore, Adms.

**Restwell Home, Inc.**
1321 Willow St., Vincennes
Warren J. Mauck, Adm.

**Vincennes Nursing Home**
1202 S. 16th St., Vincennes
Fern Junod, Adm.

### KOSCIUSKO COUNTY

**Alfran Nursing Home**
2501 E. Center St., Warsaw
Frank N. and Alice Wilson, R. N., Adms.

**Hillcrest Manor**
519 W. Winona Ave., Warsaw
Jacob P. Staltzfus, Adm.

**Kilgore Nursing Home**
R. R. 1, Pierceton
Violet Kilgore, Adm.

**Miller's Merry Manor**
R. R. 2, County Farm Rd., Warsaw
Wallace T. and Enid L. Miller, R.N., Adms.

**Orn Nursing Home**
North Main St., Milford
Mrs. Amos Orn, Adm.

**Pierceton Nursing Home**
Indiana and Main Sts., Pierceton
Frank and Alice Wilson, R.N., Adms.

**Prairie View Rest Home, Inc.**
300 Prairie St., Warsaw
Hazel Bradbury, L.P.N., Adm.

### LAGRANGE COUNTY

**Marks' Nursing Home**
R. R. 1, LaGrange
Marie B. Marks, Adm.

### LAKE COUNTY

**Blair Nursing & Convalescing Home**
7606 Rhode Island Ave., Hammond
Mary Ann Blair, L.P.N., Adm.

**Colonial House, Inc.**
119 N. Indiana Ave., Crown Point
Hilda Stuhlmacher, R.N., Adm.

**Gary Convalescent Home, Inc.**
386 Mount St., Gary
Joseph Shapiro, M.D., Adm.

**Gearlds Rest Home**
726 Sibley St., Hammond
Vida B. Gearlds and Mary H. Mashburn, Adms.

**Great Oaks Nursing and Convalescent Home**
R. R. 1, Box 30, Cedar Lake
Richard T. Davis, Adm.

**Green's Home**
3960 Massachusetts St., Gary
Lillian Green, Adm.

**Jayne Bryant Nursing Home**
P. O. Box 166, Crown Point
Ellen Jayne Bryant, Adm.

**Lake County Convalescent Home**
114 County Road O, Crown Point
Joseph J. Kish, Adm.

**Laura S. Beaton Nursing Home, Inc.**
521 Pennsylvania St., Gary
Laura S. Beaton, Adm.

**Maplecrest Nursing Home**
P. O. Box 114, St. John
George and Cecilia Klisurich, Adms.

**Miller Nursing Home**
2301 Adams St., Gary
Ida Miller, Adm.

**Mills Rest Home**
5011 Maryland St., Gary
Audrey Mills, Adm.

**S & S Nursing Home**
1944 Maryland St., Gary
LaGora Sanders and Anna L. Simmons, Adms.

**St. Ann's Home**
5927 Columbia Ave., Hammond
Sister Mary Laura, Adm.

**St. Anthony's Convalescent Home**
R. R. 1, Box 262, Crown Point
Sister Mary Ottilia, Adm.

**Shady Heights Nursing Home**
R. R. 1, Box 46, Dyer
Faye McGuire, L.P.N., Adm.

**West End Nursing Home**
1501 Wheeler St., Gary
Henderson D. Hall, Adm.

**West Side Nursing Home**
829 W. Third Ave., Gary
Stuart Primack, Adm.

**Wildwood Manor, Inc.**
1964 Clark Rd., Gary
Tomye D. Calloway, L.P.N., Adm.

**Willowdale Convalescent Home**
R. R. 2, Box 410, Crown Point
Donald D. DuSold, M.D., Adm.

**Woodmar Nursing Home**
6727 Baring Ave., Hammond
Geraldine Wiseley, Adm.

### LAPORTE COUNTY

**Anderson Sanitarium, Inc.**
1702 I St., LaPorte
Carroll and Lula Anderson, Adms.

**Beach Cliff Lodge Nursing Home**
1001 Lake Shore Dr., Michigan City
Theodore Moss, Adm.

**Hampton Nursing Home**
Michigan and Wolfe Ave., Michigan City
Charlie and Mary Hampton, Adms.

**Schofield Home**
602 Spring Street, Michigan City
Florence D. Schofield, Adm.

**Stites School Nursing Home**
State Rd. 39 and County Rd. 900 N., LaPorte
Roger J. Schofield, Adm.

**Waterford Nursing Home**
R. R. 3, Box 319, Michigan City
Mary Ellen Poffenberger, Adm.

**Wheeler Boarding Home**
Kingsbury
Jessie Wheeler, Adm.

**White Tower Nursing Home**
209 State Street, La Porte
Jane E. Gittings, Adm.

### LAWRENCE COUNTY

**Blackburn Rest Home**
519 H St., Bedford
Stella J. Blackburn, Adm.

**Glady's Nursing Home**
51 East 16th St., Bedford
Gladys Keller, Adm.

**Oolitic Rest Home**
North Lafayette St., Oolitic
Edna Perry, Adm.

**Parkview Nursing Home**
2111 Norton Lane, Bedford
Irma C. Hendricks, L.P.N., Adm.

**Rest Haven Nursing Home**
1010 W. Frank St., Mitchell
Kathleen King and Dorothy Sheeks, Adms.

**Sunny Acres Rest Home**
R. R. 5, Bedford
Mabel Ray, Adm.

**Vice Room and Board Home**
304 W. Main St., Mitchell
Zora Vice, Adm.

### MADISON COUNTY

**Bradford Nursing Home**
625 W. Adams St., Alexandria
Alma Bradford, Adm.

**Bright Memorial Nursing Home**
2006 Jackson St., Anderson
Evelyn E. Teter, Adm.

**Cook Rest Home**
424 Ruddle Ave., Anderson
Ella Cook, Adm.

**Dickey Nursing Home**
220 N. Ninth Street, Elwood
Louise Dickey, L.P.N., Adm.

**Goble Home**
332 W. 11th St., Anderson
Martha Keller, L.P.N., Adm.

**Miramar Nursing Home**
1901 N. "A" St., Elwood
James G. Dickey, Adm.

**New Haven Nursing Home**
1023 E. Eighth St., Anderson
Josephine Wade, L.P.N., Adm.

Continued

# NURSING HOMES

Continued

**Northside Nursing Home**
900 North J. St., Elwood
Louise Dickey, L.P.N., Adm.

**Scott Nursing Home**
339 S. Broadway, Pendleton
Ruby Scott, Adm.

**Shipley's Nursing Home**
2417 Pearl St., Anderson
Mildred Shipley, Adm.

**Westside Nursing Home**
416 W. 12th St., Anderson
Marian Webb, L.P.N., Adm.

## MARION COUNTY

**A & A Rest Home**
1429 Carrollton Ave., Indianapolis
Donald F. and Dorothy Hudson, L.P.N., Adms.

**Ada's Golden Age Sanitorium**
2115 Central Ave., Indianapolis
John Gerhart, Adm.

**Alpha Home for Aged**
1840 Senate Ave., Indianapolis
Maude Gaillard, Adm.

**Anthony Hall Nursing Home**
2135 N. Alabama St., Indianapolis
James W. and Marceline Jones, R.N., Adms.

**The Barton House**
505 N. Delaware, Indianapolis
Stephen J. Snyder, Adm.

**Bel-Terrace Nursing Home**
1629-33 N. College Ave., Indianapolis
Stephen J. Snyder, Adm.

**Booker-Watts Nursing Home**
2523 Central, Indianapolis
Geneva Watts, Adm.

**Borinstein Home for Jewish Aged, Inc.**
3516 Central Ave., Indianapolis
Bill Newman, Adm.

**Chateau de Repos, Inc.**
5025 W. 52nd St., Indianapolis
Doris E. Stuart, L.P.N., Adm.

**Colonial Crest, Inc.**
7149 E. 21st St., Indianapolis
Twyla L. Cross, Adm.

**Conner Nursing Home**
1408 N. Pennsylvania St., Indianapolis
Lucy V. Conner, Adm.

**Dumas Nursing Home**
2712 N. Illinois, Indianapolis
Mary Lou Dumas, R.N., Adm.

**Evangelistic Center, Inc.,**
3518 Shelby, Indianapolis
Rev. E. P. Qualls, Adm.

**Frame Nursing Home**
373 N. Holmes Ave., Indianapolis
Bert and Marybell Frame, Adms.

**Garfield Park Nursing Home**
2605 Shelby Street, Indianapolis
Thelma Bryant, L.P.N., Adm.

**Garner's Nursing Home**
1402 Carrollton Ave., Indianapolis
Elizabeth Garner, Adm.

**Greenview Manor Nursing Home**
1700 N. Illinois St., Indianapolis
Karl J. Dickerson, Adm.

**Harris Sanatorium, Inc.**
4601 N. Keystone, Indianapolis
John G. Harris, Adm.

**Hillside Nursing Home**
2370 Hillside Ave., Indianapolis
Bennie Mason, Adm.

**Huff's Sanitarium**
115 S. Audubon Rd., Indianapolis
Bettina Sullivan, Adm.

**Independent Living Boarding Home**
6038 W. 25th St., Indianapolis
Paul E. Roland, Adm.

**Indianapolis Home for the Aged, Inc.**
1731 N. Capitol Ave., Indianapolis
Burke Nicholas, Adm.

**The Lou-Wise**
2516 Central Ave., Indianapolis
Bessie Cook, L.P.N., Adm.

**Lynhurst Nursing Home**
5225 W. Morris St., Indianapolis
James H. Hill, Sr., and Ethel L. M. Herron, Adms.

**Marie Fred Nursing Home**
604 N. Jefferson Ave., Indianapolis
Marie Fred, R.N., Adm.

**Marion County Home**
R. R. 10, Box 333, Indianapolis
Robert F. Oldham, Adm.

**Memorial Nursing Home, Inc.**
41 W. 32nd St., Indianapolis
Richard L. Albright, Adm.

**Midland House, Inc.**
3302 Washington Blvd., Indianapolis
Thomas C. Keller, Adm.

**Northwestern Convalescent Home**
2413 Northwestern Ave., Indianapolis
James H. McKenzie, Adm.

**People's Nursing Home**
2354-56 N. College Ave., Indianapolis
Rev. James and Marceline Jones, R.N., Adms.

**Petty Nursing Home**
2432 Central Ave., Indianapolis
Gailord S. and Elsie Petty, Adms.

**Pleasant View Rest Home**
5000 Southeastern Ave., Indianapolis
Laura E. Weber, Adm.

**St. Paul Baptist Church Home for the Aged**
1141-45 N. Sheffield Ave., Indianapolis
Rev. C. J. Dailey, Adm.

**St. Paul Hermitage**
501 N. 17th St., Beech Grove
Sister Mary Philip Seib, O.S.B., Adm.

**Sarah's Nursing Home**
2716 Sutherland Ave., Indianapolis
Sarah Hill, Adm.

**Springer's Nursing Home**
6566 W. Washington St., Indianapolis
Millard and Gladys Springer, Adms.

**Tall Cedars Home**
8327 W. Washington St., Indianapolis
Ora A. Torrence, Adm.

**T. Wray Nursing Home**
1812 Central Indianapolis
Thelma F. Wray, L.P.N., Adm.

**Three Sisters Nursing Home**
125 W. 26th St., Indianapolis
Esther, Etta and Horty Springfield, Adms.

**Vollmer Convalescent Home**
2630 College Ave., Indianapolis
Emory H. Vollmer, Adm.

**Mabel S. Waddle Private Home**
2112 N. Delaware St., Indianapolis
Mabel S. Waddle, Adm.

**Ward Nursing Home**
1518 N. Senate Ave., Indianapolis
Willa Mae Murray, Adm.

**Weber Convalescent Home**
43 S. Ritter Ave., Indianapolis
Laura E. Weber, Adm.

**Wert Nursing Home**
1716-18 N. New Jersey, Indianapolis
Edith M. Wert, Adm.

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An imbalance of water-soluble vitamins and chronic illness often go hand in hand. STRESSCAPS, containing therapeutic quantities of vitamins B and C, is formulated to meet the increased metabolic demands of patients with physiologic stress. In chronic illness, as with many stress conditions, STRESSCAPS vitamins are therapy.

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| Vitamin $B_1$ (Thiamine Mononitrate) | 10 mg. |
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| Niacinamide | 100 mg. |
| Vitamin C (Ascorbic Acid) | 300 mg. |
| Vitamin $B_6$ (Pyridoxine HCl) | 2 mg. |
| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
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# NURSING HOMES

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**Wooldridge Nursing Home**
624 E. 12th St., Indianapolis
Albert H. and Patricia A. Wooldridge, Adms.

### MARSHALL COUNTY

**Fairview Nursing Home**
Route 4, Plymouth
Mabel Beam, Adm.

**I.B.M. Nursing Home**
1029 W. Jefferson St., Plymouth
Iva B. Miller, Adm.

**Klapp Nursing Home**
145 S. Michigan, Argos
Doris I. Klapp, Adm.

**Landis Nursing Home**
115 S. Maple Ave., Argos
Nerla L. Dykes, Adm.

**Marshall County Home**
R. R. 5, Plymouth
Warren Locker, Adm.

**Myers Nursing Home**
R. R. 3, Box 159, Bremen
Pearl Myers, L.P.N., Adm.

**R.N. Nursing Home**
Teegarden
Laura M. Hathaway, R.N., Adm.

### MARTIN COUNTY

**O'Maley Rest Home**
R. R. 4, Loogootee
Fred W. O'Maley, Adm.

### MIAMI COUNTY

**Armstrong's Park View Rest Home**
402 Armstrong Ave., Peru
Zella C. Armstrong, L.P.N., Adm.

**Church of the Brethren Home, Inc.**
Mexico
Orville Sherman, Adm.

**Miami County Home**
R. R. 5, Peru
Bruce Babbs, Adm.

**The Miami Home**
77 E. Third St., Peru
H. Lucille McDaniel, Adm.

**Peru Nursing Home**
906 W. Main St., Peru
Margaret Harris, L.P.N., Adm.

### MONROE COUNTY

**Arbutus Rest Home**
R. R. 2, Box 46, Bloomington
Floyd and Hazel Hall, Adms.

**Lemble Nursing Home**
R. R. 7, Box 297, Bloomington
Judith Lemble, Adm.

### MONTGOMERY COUNTY

**Ben Hur Home**
1375 S. Grant, Crawfordsville
Martha E. Williams, Adm.

**Friendship House**
209 W. Main St., Ladoga
Hazel G. Kesterson, Adm.

**Hazel Small Rest Home**
N. Vine St., Waynetown
Lee and Sarah Small, Adms.

**Laura M. Bowles Convalescent Home, Inc.**
1304 S. Grant Ave., Crawfordsville
Richard Bowles, L.P.N., Adm.

**Westbrook Nursing Home**
R. R. 9, Box 39, Crawfordsville
Mary E. Brooks, Adm.

### MORGAN COUNTY

**Cherry Nursing Home**
60 E. Harrison St., Martinsville
Lillian Frye, Adm.

**Kennedy Memorial Christian Home**
210 W. Pike St., Martinsville
Dr. W. Dean Mason, Adm.

**Morgan County Home**
190 S. Main St., Martinsville
Earl B. Fletcher, Adm.

**Sullivan Nursing Home**
Box 162, Morgantown
Marjorie Sullivan, Adm.

### NOBLE COUNTY

**C. J. Hocker Memorial Nursing Home**
Wolflake
Thomas Wheeler and Lou Ann Foster, Adms.

**Golden Rule Nursing Home**
R. R. 1, Pierceton
H. F. and Eva Mock, Adms.

**Jaquay's Nursing Home**
324 Silver St., Kendallville
Leone Jaquay, Adm.

**Kondas Nursing Home**
R. R. 1, Albion
Steve Kondas, Adm.

**Lutheran Old People's Home, Inc.**
612 E. Mitchell, Kendallville
Rev. Herbert L. Wiese, Adm.

**Sacred Heart Home**
R. R. 2, Avilla
Sister Mary Emma, Adm.

**Saint Vincent Home for the Aging**
R. R. 1, Ligonier
Sister M. Agatha, R.N., Adm.

### ORANGE COUNTY

**Gorge Nursing Home, Inc.**
R. R. 2, French Lick
Gertrude Haynes, R.N., and Myrtle Simpson, R.N., Adms.

### OWEN COUNTY

**Donna Nursing Home #2**
R. R. 2, Spencer
Norman S. Tirsway, Adm.

**Gosport Nursing Home**
W. Main St., Gosport
Mary F. Wampler, Adm.

**Reapp Nursing Home**
P. O. Box 87, Spencer
Jennie C. Reapp, Adm.

### PARKE COUNTY

**Allen Nursing Home**
303 Howard Ave., Rockville
James F. Allen, Adm.

**Ball Nursing Home**
517 Ohio St., Rockville
Margaret Ball, Adm.

**Bishop's Nursing Home**
South Main St., Box 58 Bloomingdale
Darrell H. Bishop, Adm.

**Britton's Parke County Nursing Home**
R. R. 2, Rockville
Helen Britton, Adm.

**Sanders Nursing Home**
Mecca
Collett and Evelyn Sanders, Adms.

**Wabash Valley Nursing Home**
934 N. Jefferson St., Montezuma
Darvin and Wilma Busenbark, Adms.

### PERRY COUNTY

**Lincoln Hills Nursing Home, Inc.**
19th and Pestalozzi, Tell City
C. Bayless Conley, Adm.

### PIKE COUNTY

**Fay's Convalescent Home**
210 S. 14th St., Petersburg
Fay France, Adm.

**Petersburg Rest Home**
1002 Main St., Petersburg
Donna M. Butrum, Adm.

### PORTER COUNTY

**Beverly Shores Nursing Home, Inc.**
Beverly Shores
John W. Bragg, Adm.

**Whispering Pines Home for Senior Citizens**
N. Calumet Rd., Valparaiso
Mary E. Bartz, Adm.

### POSEY COUNTY

**Allison Nursing Home**
Locust St., Poseyville
Lula Allison, Adm.

Continued

## to help relieve pain in common anorectal disorders

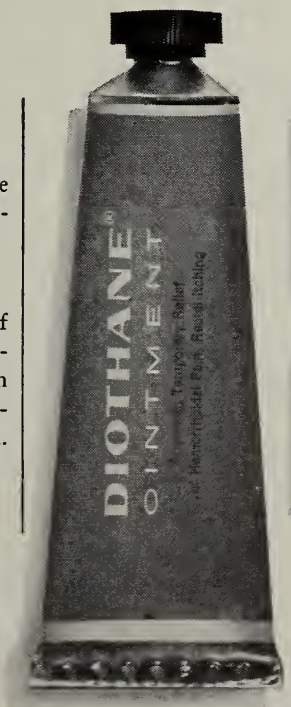
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Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

**DIOTHANE OINTMENT**

COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.







**DIOTHANE SUPPOSITORIES**

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
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**The Charles Ford Memorial Home**
New Harmony
Harry S. Glump, Adm.

**Mt. Vernon Nursing Home**
831 Mulberry St., Mount Vernon
Rena Green, Adm.

**Posey County Home**
Poor Infirmary Rd., R. R. 4, Mt. Vernon
Edith Hester, Adm.

**The Valley Rest Home**
R. R. 4, Mount Vernon
Raymond E. and Esther M. Faulkner, Adms.

### PUTNAM COUNTY

**Craver Nursing Home**
"E" Street, Greencastle
Hannah Craver, Adm.

**Donna Nursing Home #1**
Main St., Cloverdale
Norman S. Tirsway, Adm.

**Eventide Rest Home**
R. R. 2, Greencastle
Cletus O. and Daisy L. Sult, R.N., Adms.

**Greencastle Christian Home**
113 S. Jackson St., Greencastle
Rev. L. C. Ziegler, Adm.

**Putnam County Home**
R. R. 3, Greencastle
Dorothy Irwin, Adm.

**Ruark Nursing Home**
R. R. 1, Fillmore
Elsie C. Ruark, Adm.

### RANDOLPH COUNTY

**Lamb's Nursing Home**
R. R. 4, Union City
Bernice A. Lamb, L.P.N., Adm.

**Parrott's Home**
304 W. Sherman St., Lynn
Willis R. and Mary Maxine Parrott, Adms.

### RIPLEY COUNTY

**Dreyer Nursing Home**
S. Main St., Sunman
Edward and Anna Davis, Adms.

**Gilland Nursing Home #1**
310 Cravens St., Osgood
Dan and Mildred Gilland, Adms.

**Gilland Nursing Home #2**
120 E. Ripley St., Osgood
Dan and Mildred Gilland, Adms.

**Gilland Nursing Home #3**
Glasgow and Willson, Osgood
Dan and Mildred Gilland, Adms.

**Health and Hospitality Center**
Carr St., Milan
Alfred J. Colson, Adm.

**Schwing Nursing Home**
R. R. 1, Sunman
Donald J. Schwing, Adm.

**Twilight Haven Convalescent Home**
High Street, Versailles
Freeda Hensley, Adm.

### RUSH COUNTY

**Hillside Haven**
424 North Perkins St., Rushville
Mary Todd, R.N., Adm.

**Howard Rest Home**
Railroad St., Milroy
Deloris Howard, Adm.

**Jackson Nursing Home**
114 E. Fifth St., Rushville
Marjorie Pearsey, L.P.N., and Goldie C. Jackson, L.P.N., Adms.

**Rowland's Nursing Home**
230 E. Seventh St., Rushville
Willard and Nora Lee Rowland, Adms.

**Rushville Nursing Home**
321 N. Morgan St., Rushville
Marjorie Fordyce, Adm.

### ST. JOSEPH COUNTY

**Barbara Morrow Home**
1107 S. Main St., South Bend
Barbara Morrow, Adm.

**Calvert Convalescent Home**
1844 E. Calvert, South Bend
Alma Williams, Adm.

**Cardinal Nursing Home, Inc.**
118 S. Williams St., South Bend
Thomas E. Squibb, Adm.

**Columbia Nursing Home**
702 S. Columbia, South Bend
William G. Swintz and Thomas E. Squibb, Adms.

**Dodge Home for Old People**
318 E. Third St., Mishawaka
Lois Moore, Adm.

**Dor-A-Lin, Inc.**
1024 N. Notre Dame Ave., South Bend
Edward L. Finkenbinder, Adm.

**Farris Nursing Home**
1021 W. Washington St., South Bend
Helen M. Farris, Adm.

**Farris Nursing Home #2**
1044 Lincolnway West, South Bend
Helen M. Farris, Adm.

**Haven Hubbard Memorial Home**
New Carlisle
Mearl L. Dustin, Adm.

**Hillview Convalescent Home**
601 Russell St., Mishawaka
Rosabelle Buck, R.N., Adm.

**Krogh Nursing Home**
109 N. Cedar St., Mishawaka
Joyce Wood, L.P.N., Adm.

**Lambie Nursing Home**
832 W. Colfax St., South Bend
Audrey J. Lambie, Adm.

**Nemeth Nursing Home**
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Peggy and Michael Nemeth, Adms.

**Oak Haven Rest Home**
714 W. Oak St., South Bend
Myrtle B. Joyce, Adm.

**River Park Nursing Home**
2706 Wall St., South Bend
William G. Swintz and Thomas E. Squibb, Adms.

**River Park Nursing Home #2**
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William G. Swintz and Thomas E. Squibb, Adms.

**Robert P. and Clara I. Milton Home, Inc.**
206 E. Marion St., South Bend
Myrtle Caldwell, Adm.

**Rockhill Nursing Home**
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Lillie A. Rockhill, L.P.N., Adm.

**Susie H. Beiger Old Ladies Home**
317 Lincolnway East, Mishawaka
Lois Moore, Adm.

**Terry King Nursing Home**
816 W. Colfax, South Bend
Calvin Laisure, Adm.

**Terry King Nursing Home**
1209 S. Union, Mishawaka
Gloria McCullough, Adm.

**Walkerton Nursing Home**
500 Roosevelt Road, Walkerton
Virginia Waldron, L.P.N., Adm.

**Wilton Rest Home**
25419 St. Rt. 2, South Bend
William Grzywinski, Adm.

### SCOTT COUNTY

**Shalom Nursing Home**
Highway 31 South, Scottsburg
Marvin L. and Patricia Richey, Adms.

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R. R. 1, Fairland
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Charles Conover, Adm.

**Shelbyville Rest Home**
125 W. Washington, Shelbyville
Laura Oma Gosch, Adm.

**Waldron Nursing Home**
Main St., P. O. Box 127, Waldron
Evelyn V. Nasby, R.N., Adm.

### SPENCER COUNTY

**Boyd Nursing Home**
513 Walnut St., Rockport
Mamie Boyd, Adm.

**Ophelia's Rest Home**
807 Main St., Rockport
Ophelia Moore, Adm.

**Spencer County Home**
R. R. 1, Rockport
Thomas P. Huff, Adm.

### STARKE COUNTY

**Healthmore Nursing Home**
P. O. Box 103, Hamlet
Paul Q. and Berniece Zellers, R.N., Adms.

**Knox Nursing Home**
302-306 Culver St., Knox
Pearl Myers, L.P.N., Adm.

**Little Company of Mary Hospital and Health Facility**
Route 421, San Pierre
Mother M. Catherine, Adm.

### STEUBEN COUNTY

**Adams Nursing Home**
314 W. Broad St., Angola
Lois June Adams, Adm.

**Angola Rest Home, Inc.**
306 N. Wayne St., Angola
Ruth G. Libby, Adm.

**Edith Nursing Home**
116 Powers St., Angola
Helen Taylor, Adm.

**Steuben County Rest Home**
R. R. 3, Angola
Harold Peters, Adm.

**Underwood Nursing Home**
Box 8, Defiance St., Pleasant Lake
Paul and Mary Underwood, Adms.

### SULLIVAN COUNTY

**Sullivan County Home**
R. R. 5, Sullivan
Mr. and Mrs. Orian Self, Adms.

### SWITZERLAND COUNTY

**Peelman Home**
701 W. Pike St., Vevay
Virginia Peelman, Adm.

### TIPPECANOE COUNTY

**Battle Ground Nursing Home**
Jewett St., Battle Ground
John D. Gerhart, Adm.

**Burnett Convalescent Home**
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Maude L. Golden, L.P.N., Adm.

**Comfort, Inc.**
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**Indiana Knights of Pythias Home, Inc.**
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Clarence Hole, Adm.

**Laura M. Bowles Convalescent Home**
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**Lesley Nursing Home**
Buck Creek
Rosina Lesley, Adm.

**Scott Nursing Home**
1100 N. Ninth St., Lafayette
Goldie Scott, Adm.

**Tippecanoe County Home**
R. R. 1, Lafayette
Clifford L. Cassaday, Adm.

**Tippecanoe County Home-Ross Annex**
R. R. 6, Lafayette
Lucille M. Klaiber, Adm.

### TIPTON COUNTY

**The Higgins Home**
R. R. 1, St. Rd. 19, Tipton
Robert D. and Eileen G. Higgins, L.P.N., Adms.

**Tipton County Home**
R. R. 1, Tipton
Lester Dodd, Adm.

**Tipton Nursing Home**
216 S. Conde St., Tipton
Louise Dickey, L.P.N., Adm.

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**Park Manor Nursing Home, Inc.**
409 E. Union St., Liberty
Helen Ann Ray, L.P.N., Adm.

### VANDERBURGH COUNTY

**Bethany Rest Home**
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Edith M. Poole, Adm.

**Bethel Sanitarium, Inc.**
800 Mary Street, Evansville
Louise Kuiken, R.N., Adm.

**Bethel Sanitarium, Inc.**
6015 Kratzville Rd., Evansville
Louise Kuiken, R.N., Adm.

**Bethel Sanitarium, Inc., Annex**
5827 Kratzville Rd., Evansville
Louise Kuiken, R.N., Adm.

**Boehne Convalescent Home, Boehne Hospital**
Evansville
J. E. Janzen, Adm.

**Braun's Nursing Home**
909 First Ave., Evansville
Roy L. and Ruth H. Braun, Adms.

**Dorsey Nursing Home**
1714 S. Governor St., Evansville
Laura Dorsey, Adm.

**Gertha's Nursing Home**
605 Oakley St., Evansville
Gertha Hendrickson, Adm.

**Good Samaritan Home**
601 N. Boeke, Evansville
Rev. Martin P. Kniker, Adm.

**Kueber Nursing Home**
816 First Avenue, Evansville
Robert E. Arendell, M.D., Adm.

**M & R Nursing Home**
1100 N. Read St., Evansville
Mrs. Muriel Sprinkle, L.P.N., Adm.

**Newton Rest Home**
921-23 S. Elliott St., Evansville
Mary Alice Kennedy, Adm.

**Pine Haven**
3401 Stocker Dr., Evansville
Anita M. Stocker, R.N., Adm.

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1320 S. E. Second St., Evansville
M. D. Guenther, Adm.

**Regina Pacis Home**
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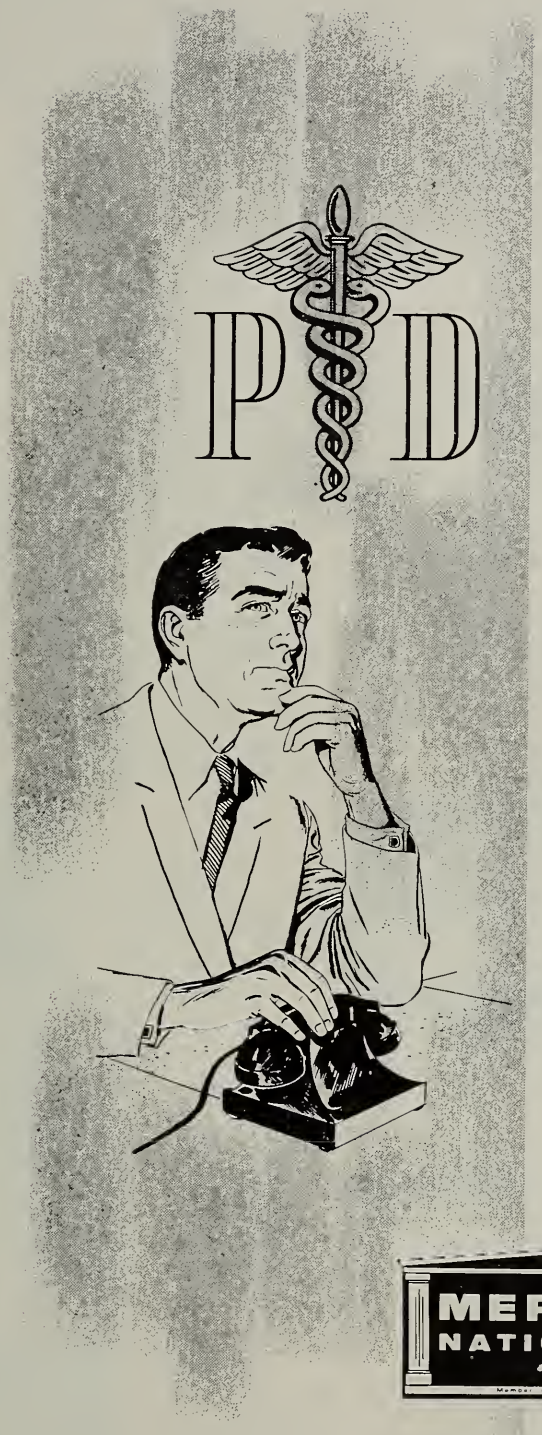
**Stinson Rest Home**
315 S. E. Second St., Evansville
Mildred Stinson, Adm.

**Thelma's Rest Home**
807-11 S. E. Third St., Evansville
Thelma Shaw, Adm.

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# NURSING HOMES

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Louise Barton, Adm.

**Layman Nursing Home**
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Mildred Layman, Adm.

**Vermillion County Nursing Home**
R. R. 1, Hillsdale
Mr. and Mrs. Paul Shew, Adms.

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**Allendale Nursing Home**
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Lucille McCoskey, Adm.

**Brandon Residence for Elderly People**
220 N. Fourth St., Terre Haute
Margaret L. Bartch, Adm.

**Clara Fairbanks Home for Aged Women, Inc.**
721 Eighth Ave., Terre Haute
Florine Van Arsdall, Adm.

**Ezell Boarding Home**
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Ruby Ezell, Adm.

**Happy Years Rest Home**
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Rev. E. E. and Mary J. Pugh, Adms.

**Ideal Rest Home**
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Clarence and Evelyn Wallace, Adms.

**Mary Etta Nursing Home**
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Mamie Mason, Adm.

**Meadows Manor**
Brown at Poplar St., Terre Haute
Jane Lee Jenkins, Adm.

**Sharps Nursing Home**
1432 N. Center St., Terre Haute
Hazel M. Sharps, Adm.

**Trainer Nursing Home**
1915 N. 11th St., Terre Haute
Geneva Trainer, Adm.

**Vigo County Home**
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Carl Koile, Adm.

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Evelyn Wallace, Adm.

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Seventh and Buffalo, North Manchester
William Visser, Adm.

**Friendly Nursing Home, Inc.**
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Jean Leakey, Adm.

**Gore's Nursing Home**
1250 Pike St., Wabash
Chester M. Gore, Adm.

**Pleasant View Nursing Home**
R. R. 2, Wabash
Virgil L. and Lois M. Sweares, Adms.

### WARREN COUNTY

**Pleasant Valley Retirement and Convalescent Lodge**
Kramer
Walter R. and Dorothy D. Ruark, R.N., Adms.

### WARRICK COUNTY

**Baker's Rest Haven**
503 West Walnut, Boonville
Viola Baker, L.P.N., Adm.

**Hollis Nursing Home**
R. R. 5, Boonville
Harvey and Loraine Hollis, Adms.

**Shady Rest Nursing Home**
Outer State Street, Chandler
Gilbert and Pearl Bradfield, Adms.

**Thornton Home-Stitt Infirmary**
E. Jennings Lane, Newburg
Minnie Highsmith, Adm.

### WASHINGTON COUNTY

**Williams Convalescent Center, Inc.**
Homer and Anson Sts., Salem
Kathleen Williams, L.P.N., Adm.

**Williams Nursing Home**
R. R. 3, Scottsburg
Kathleen Williams, L.P.N., Adm.

### WAYNE COUNTY

**Friendship Home**
306 S. 10th St., Richmond
Grace Flatley, Adm.

**Gains Nursing Home**
R. R. 2, Richmond
Emma Gains, Adm.

**Glen Aire Nursing Home**
2116 E. Main St., Richmond
Helen Marshall and Eileen Singleton, Adms.

**Golden Rule Nursing Home #1**
47 S. Seventh St., Richmond
Hilda Stull, L.P.N., Adm.

**Golden Rule Nursing Home #2**
320-22 N. 10th St., Richmond
Hilda Stull, L.P.N., Adm.

**Good Will Rest Home**
500 W. Main, Cambridge City
Nell Osborne, Adm.

**Hagerstown Nursing Home**
801 W. Main St., Hagerstown
F. Anna Barnes, Adm.

**Hilling's Nursing Home**
R. R. 1, Box 237, Centerville
Betty L. Hilling, Adm.

**Jenkins Hall**
N. 10th St., Richmond
G. Dale Splitstone, Adm.

**Mary E. Hill Nursing Home for Aged Colored Women, Inc.**
2308 Zoar Ave., Richmond
Howard Alexander, Adm.

**Pinehurst Nursing Home**
R. R. 1, Centerville
Bonnie Cole, Adm.

**Twin Pines Nursing Home**
Main St., Economy
Elizabeth Johnson, Adm.

### WELLS COUNTY

**Clark Nursing Home**
522 E. South St., Bluffton
Robert H. and I. Evelyn Sprinkle, Adms.

**Cooper Rest Home**
306 W. Wabash Ave., Bluffton
Janet E. Cooper, R.N., Adm.

**Davis Nursing Home**
627 S. Marion St., Bluffton
Helen Davis, Adm.

**Southview Rest Home**
R. R. 3, Box 306, Bluffton
Cora N. Anderson, L.P.N., Adm.

### WHITE COUNTY

**Allen's Nursing Home**
621 N. Illinois, Monticello
Goldie Allen, Adm.

**Archibald Memorial Home for Aged Deaf**
R. R. 2, Brookston
Leroy Turner, Adm.

**Lake View Home**
R. R. 6, Monticello
Esther Rumple, Adm.

**Monticello Nursing Home, Inc.**
226 N. Illinois St., Monticello
Gerald L. Eastburg, Adm.

**WHITLEY COUNTY**

**Farris Nursing Home**
209 W. Market St., Columbia City
Louise Farris, L.P.N., Adm.

**Hillcrest Home**
710 W. Ellsworth St., Columbia City
Herman O. and Edith M. Oelschlager, R.N., Adms.

**Maple Hill Nursing Home**
604 W. Vanburen St., Columbia City
Monroe Shephard, Adm.

**South Whitley Rest Home, Inc.**
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Katherine A. Bresnahan, R.N., Adm.

**Whitley County Home**
R. R. 1, Columbia City
Owen Zumbrun, Adm. ◄


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# *Poison Control Centers in Indiana*

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***** ATTENTION: Physicians, Hospitals and Poison Control Centers.**

**Commencing July 1, 1965, Marion County General Hospital, Indianapolis, Indiana, will become the principal INFORMATION CENTER for the State of Indiana replacing that service provided by the Indiana State Board of Health. If you need help in determining the toxic ingredients in a "trade name product" or have a problem involving treatment of a poisoning case, please call MARION COUNTY GENERAL HOSPITAL, INDIANAPOLIS, INDIANA — MElrose 6-6331 — Extension 211.**

| City | Name and Address | Telephone | Director |
|---|---|---|---|
| Anderson | St. John's Hickey Memorial Hospital<br>127 West 19th Street | 643-3391,<br>Ext. 82 or 35 | William L. Stephens |
| Angola | Cameron Memorial Hospital, Inc.<br>416 E. Maumee | 665-2141 | Irene Kenyon, R.N. |
| Bedford | Dunn Memorial Hospital<br>1616 23rd Street | BRowning<br>5-3331,<br>Ext. 32 | Marshall S. Wallner |
| East Chicago | St. Catherine Hospital<br>4321 Fir Street | EXport<br>7-3080 | Jack M. Troy, M.D. |
| Elkhart | Elkhart General Hospital<br>600 East Boulevard | JAckson<br>3-5350,<br>Ext. 224 | C. Richard Yoder, M.D. |
| Evansville | Protestant Deaconess Hospital<br>600 Mary Street | HArrison<br>4-8011,<br>Ext. 247 | Edward J. Wolfgang |
| Evansville | St. Mary's Hospital, Inc.<br>3700 Washington Avenue | GReenleaf<br>7-1541,<br>Ext. 328 | Kenneth Wilhelmus, M.D. |
| Evansville | Welborn Memorial Baptist Hospital, Inc.<br>412 S. E. Fourth Street | HArrison<br>3-3103<br>Ext. 336, 337 | Charles L. Warner, M.D. |
| Fort Wayne | Parkview Memorial Hospital<br>2200 Randalia Drive | 743-7341,<br>Ext. 530 | William O. Wissman |
| Fort Wayne | St. Joseph Hospital<br>730 West Berry Street | ANthony<br>4121,<br>Ext. 2663 | Miss Angeline Holbrook, R.N. |
| Frankfort | Clinton County Hospital<br>1300 S. Jackson Street | 654-4451 | Fred W. Flora, M.D. |
| Gary | Methodist Hospital of Gary, Inc.<br>1600 West 6th Avenue | 882-9461,<br>Ext. 709 | Glen T. Dresher, R. N. |

| City | Name and Address | Telephone | Director |
|---|---|---|---|
| Goshen | Goshen General Hospital<br>200 High Park Avenue | KEystone<br>3-2141<br>(Emergency<br>Room) | Willard S. Krabill, M.D. |
| Hammond | St. Margaret Hospital<br>25 Douglas Street | WEstmore<br>2-2300,<br>Ext. 700 | Herbert I. Arbeiter, M.D. |
| Indianapolis | *Marion County General Hospital<br>960 Locke Street | MElrose<br>6-6331,<br>Ext. 211 or 212 | Richard W. Dyke, M.D. |
| Indianapolis | Methodist Hospital of<br>Indiana, Inc.<br>1604 North Capitol Ave. | WAlnut<br>4-6411,<br>Ext. 752, 753<br>or 754 | Maxine Bush, R.N. |
| Indianapolis | St. Francis Hospital<br>North 17th Avenue<br>Beech Grove, Indiana | STate 7-3311 | H. N. Grimes, M.D. |
| Kokomo | Howard Community Hospital<br>3500 S. Lafountain | GL 7-6611,<br>Ext. 233, 234 | Don E. Gillaspy |
| Lafayette | St. Elizabeth Hospital<br>1501 Hartford Street | SH 2-0221,<br>Ext. 313 or 317 | Sister M. Josita |
| West<br>Lafayette | Purdue University<br>Student Health Center | 92-2446<br>Ext. 54 | Loyal W. Combs, M.D. |
| LaGrange | LaGrange County Hospital<br>R. R. #1 | 463-2144 | Merle V. Rawson |
| Lebanon | Witham Memorial Hospital<br>1124 N. Lebanon Street | LEbanon 143<br>or 2447,<br>Ext. 44 | Thomas Dillon, D.O. |
| Madison | The King's Daughters' Hospital<br>112 Presbyterian Ave. | 265-5211 | Verlie Blanc, R.N. |
| Marion | Marion General Hospital<br>Wabash and Euclid Avenue | NOrth<br>4-1228,<br>Ext. 44 | R. W. Schroeder, M.D. |
| Mishawaka | St. Joseph Hospital<br>215 West 4th Street | BLackburn<br>9-1431 | Abner H. Levkoff, M.D. |
| Muncie | Ball Memorial Hospital<br>2401 University Avenue | 284-3371,<br>Ext. 241 | Junia L. Rice, R.N. |
| Portland | Jay County Memorial Hospital<br>505 West Arch Street | 726-7131,<br>Ext. 67 | Forrest E. Keeling, M.D. |
| Richmond | Reid Memorial Hospital<br>Spring Grove | 25481,<br>Ext. 222 | Mrs. Jessie Snyder, R.N. |
| Shelbyville | William S. Major Hospital<br>150 W. Washington Street | EX 8-6661 | Carolyn Rosenfeld, R.N. |

* Poison Information Center.

| City | Name and Address | Telephone | Director |
|---|---|---|---|
| South Bend | Memorial Hospital of South Bend Poison Control Center<br>615 North Michigan Street | 234-9041, Ext. 258 | William B. Frey, M.D. |
| South Bend | St. Joseph Hospital<br>811 East Madison Street | CEntral 4-2151 | Leslie M. Bodnar, M.D. |
| Terre Haute | Union Hospital, Inc.<br>1606 N. Seventh Street | CRawford 0361, Ext. 229 | Joseph P. Gillotte, M.D. |
| Tipton | Tipton County Memorial Hospital<br>1032 S. Main Street | OSburn 5-7411 | George L. Compton, M.D. |

## ADJACENT STATES

### ILLINOIS

| City | Name and Address | Telephone | Director |
|---|---|---|---|
| Chicago | Poison Control Center<br>Presbyterian—St. Luke's Hospital<br>1753 W. Congress Pkwy. | SEeley 8-4411, Ext. 2322 | Joseph Christian, M.D. |

### KENTUCKY

| | | | |
|---|---|---|---|
| Louisville | Poison Control Center<br>Department of Pediatrics<br>323 E. Chestnut St. | JUniper 2-1831 | Thomas A. Courtenay, M.D. |

### MISSOURI

| | | | |
|---|---|---|---|
| St. Louis | Poison Control Center<br>Cardinal Glennon Memorial Hospital for Children<br>1465 S. Grand Ave. | MOhawk 4-7222, Ext. 216 | Vincent J. LoPiccolo, M.D. |
| St. Louis | Poison Control Center<br>St. Louis Children's Hospital<br>500 S. Kingshighway | FOrest 7-6880 | J. Neal Middlekamp, M.D. |

### OHIO

| | | | |
|---|---|---|---|
| Cincinnati | *Poison Control Center<br>Cincinnati Academy of Medicine<br>320 Broadway | 721-2345 | John A. Williams, M.D. |
| Columbus | Poison Control Center<br>Children's Hospital<br>17th St. at Livingston Park | CLearbrook 8-9783 | Phillip Ambuel, M.D. |

* Informational services only

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Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 8, Indiana

Please send me an application form for a Scientific Exhibit at the ISMA Annual Convention, October 12-14, 1965, Murat Temple, Indianapolis, Indiana.

I propose to exhibit_____

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# *DISEASE PREVENTION* by Immunization and Chemoprophylaxis*

| *Disease* | *Agent Used* | *Recommended For* | *Method of Administration* | *Type of Immunity* | *Duration of Protection* | *Booster Injection* |
|---|---|---|---|---|---|---|
| Cholera | Cholera Vaccine | Adults | —0.5 cc. subcutaneously followed by 1.0 cc. in 7 days. | Active | 6 months | 0.12-1.0 cc. according to age every six months in endemic areas. |
| | | Children:<br><br>6 months to 2 years<br>3-6 years<br>7-10 years<br>11 years and older | Three subcutaneous injections given 7-10 days interval.<br>(1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc.<br>(1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc.<br>(1) 0.25 cc.; (2) 0.5 cc.; (3) 0.5 cc.<br>Adult schedule | | | |
| Diphtheria | Diphtheria Antitoxin | All early cases | Usually intramuscular if seen within 48 hours of onset. *Warning:* Test for sensitivity to horse serum. May be used intravenously in severe nasopharynx cases. Dosage dependent on degree of toxicity rather than age and weight. 10,000 units to 75,000 units. | Passive | Short | Additional antitoxin given dependent upon illness and toxicity. |
| Diphtheria | Diphtheria Toxoid (fluid or alum precipitated or aluminum phosphate adsorbed, for adult use) | Children older than 11 years and adults | Two intramuscular injections of 0.5 cc. each, four to six weeks apart for primary immunization or if individual has not had a booster dose of vaccine for 3 years. | (If toxoid is given then active immunity develops.) | Indefinite | 0.5 cc. every year. |
| Diphtheria | Diphtheria-Pertussis-Tetanus alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed diphtheria and tetanus toxoids; containing 12 protective antigenic units of vaccine per 1.5 cc. (DPT) | Children under 5 years | (1) First dose of 0.5 cc. deep intramuscularly—follow injection with 0.1-0.2 cc. air. Given 1-3 months age.<br>(2) Second dose of 0.5 cc. deep intramuscularly one month after first dose.<br>(3) Third dose of 0.5 cc. deep intramuscularly one month after 2nd dose.<br>(4) If 1st dose given earlier than 3 months of age, then give fourth dose 2-3 months after series completed. | Active | Indefinite | D. P. T. booster of 0.5 cc. at 12 to 18 months and 4-5 years. After 5 years booster dose of 0.5 cc. Diphtheria Tetanus Toxoid every 3 years to age 11 years. |
| Diphtheria | Diphtheria Tetanus Toxoid alum precipitated or aluminum hydroxide (or aluminum phosphate) adsorbed. | Children over 5 years and up to 10 years | (1) First dose of 0.5 cc. deep intramuscularly, follow injection with 0.1-0.2 cc. air.<br>(2) Second dose of 0.5 cc. deep intramuscularly—follow injection with 0.1-0.2 cc. air. | Active | Indefinite | Diphtheria Tetanus booster 0.25 cc. to 0.5 cc. *Caution:* Do not give to children past 10 years of age. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Diphtheria | Diphtheria Toxoid Pertussis Vaccine Tetanus Toxoid Fluid | Rapid immunization of children under 10 years | Three doses of 0.5 cc. given subcutaneously at intervals of 3-4 weeks. In face of epidemic injections may be given at one week intervals. | Active | Antigenic response lower than with the alum preparations and does not last as long. | 0.5 cc. every 2 years. |
| Diphtheria | Diphtheria Toxoid Tetanus Toxoid Fluid | Rapid immunization under 10 years | Three doses 0.5 cc. given subcutaneously at intervals of 3-4 weeks. In face of epidemic injections may be given at intervals of one week. | Active | Antigenic response lower than with alum preparations and does not last as long. | 0.5 cc. every 2 years. |
| Hepatitis, Infectious (Epidemic) | Immune Serum Globulin (Gamma Globulin) | All exposed in household, institution, etc. | Dosage: 0.01 cc. per pound of body weight. Given intramuscularly. | Passive | Brief | Repeat each exposure. |
| Influenza | Polyvalent Vaccine | Use during epidemics | | Active (in 70% + immunized) | Short: 3-4 months | Repeat primary injection and/or injections annually. |
| | | Children | Give total of 1.0 cc. in the course of one week. | | | |
| | | Adults—especially all with chronic debilitating disease of heart and lungs. | 1.0 cc. subcutaneously. *Warning:* Precautions must be taken in individuals sensitive to egg protein. *(Note:* There is less chance of local or systemic reaction if only 0.1 cc. is given intradermally for a total of 2 doses 7-10 days apart). | | | |
| Measles | | | | | | |
| (1) | Live, Attenuated Vaccine | 12 months and older | 1 | Active | Unknown | Although the live, attenuated vaccine may be administered safely with or without the simultaneous administration of Measles Immune Globulin, most physicians will wish to use the two combined because of the lessened frequency of clinical reactions. |
| (2) | Live, Attenuated Vaccine plus Measles Immune Globulin | 12 months and older | 1 plus Measles Immune Globulin (.01 cc per pound at different site with different syringe) | Active | Unknown | The live attenuated vaccines should be administered only to those 12 months of age or older since residual maternal antibody may interfere with a satisfactory response among younger children. |

| Disease | Agent Used | Recommended For | Method of Administration | Type of Immunity | Duration of Protection | Booster Injection |
|---|---|---|---|---|---|---|
| Measles | | | | | | |
| (3) | Live, "Further Attenuated Vaccine" | 12 months and older | 1 | Active | Unknown | Clinical reactions following the "Further Attenuated Vaccine" are relatively infrequent; Measles Immune Globulin is not necessary with this Vaccine. |
| (4) | Inactivated Vaccine | Any Age | 3* (monthly intervals) plus a booster dose after one year | Active | Unknown | In view of the rapid fall-off in antibody and evidence of decreasing immunity following a primary immunization series, use of this vaccine is not preferred except for special groups in which live attenuated vaccine is contraindicated. The degree and duration of protection which might be afforded to those given a booster has not yet been determined. |
| (5) | Inactivated Vaccine followed by Live, Attenuated Vaccine | 12 months and older | 1 dose inactivated vaccine followed in 1 to 3 months by 1 dose live attenuated vaccine | Active | Unknown | The preceding administration of inactivated vaccine serves to reduce the frequency and severity of clinical reactions following live attenuated vaccine administration. |
| | | Under 12 months | 3 doses inactivated vaccine at monthly intervals followed by 1 dose live attenuated vaccine at 12 months of age or older. | Active | Unknown | The live attenuated vaccine should be administered only to those 12 months of age or older since residual maternal antibody may interfere with a satisfactory response among younger children. |

* In view of rapidly declining antibody levels and protection, at least one booster dose about a year later is necessary. Data are not yet available to indicate when or with what frequency additional booster doses might be required.

| | | | | | | |
|---|---|---|---|---|---|---|
| Meningococcic Meningitis | Sulfadiazine | Control of exposed persons in community groups<br>Children up to 11 yrs. | 0.5 m. twice daily for 2 days. | None<br>Chemical prophylaxis only | Very brief—for one exposure only. | Repeat following each exposure. |
| | | Adults (and children 12 yrs. or over) | 1.0 gm. twice daily for 2 days. | | | |
| Mumps | Mumps Vaccine | Adults exposed to case and with negative history of having had mumps | *Warning:* Check on sensitivity to egg protein. Two injections given 5 to 10 days apart of 1.0 cc. each subcutaneously. | Active | Brief | Previously immunized persons may be given booster dose of 0.5 to 1.0 cc. subcutaneously. |
| Pertussis | Pertussis Vaccine saline suspended (See Double and Triple antigens under "Diphtheria") | Children during epidemic | A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units (0.5 cc.) given subcutaneously at intervals of one week. | Active | Indefinite | 1 year after primary series, 2 years after primary series and then every three years to 6 or 7 years of age. |
| | Pertussis Vaccine alum precipitated or aluminum hydroxide adsorbed (See Double and Triple antigens under "Diphtheria") | Routine immunization of infants when DPT is contraindicated | A total of 12 N. I. H. units divided into 3 equal doses of 4 N. I. H. units each (0.5 cc.) injected intramuscularly at intervals of 4 to 6 weeks. | Active | Indefinite | 18 months—3-4 years. 6-7 years usually given as DPT. |
| | | Exposure Recall | | Active | Indefinite | .4 NIH units (0.5 cc.) saline suspension subcutaneously if child has not had immunization past 2 years. |
| Plague | Plague Vaccine—a suspension of 2000 million killed Pasteurella per milliliter | Epidemics and areas with high endemic rate. Adults: | Two injections subcutaneously 7-10 days apart. First injection 0.5 cc.; second, 1.0 cc. | Active | Partial protection for period of 4-6 mos. | 1.0 cc. every 4 months as long as danger of epidemic exists. |
| | | Children:<br>6 months-2 years<br>2 years-6 years<br>6 years-10 years | 0.06 cc.; 0.12 cc; 0.12 cc.<br>0.12 cc.; 0.25 cc.; 0.25 cc.<br>0.25 cc.; 0.50 cc.; 0.50 cc. | Active | Partial protection for period of 4-6 mos. | Booster dose for children is same as first dose of initial series. |
| Poliomyelitis* | Poliomyelitis (Salk) Vaccine | All Ages | Two injections each 1.0 cc. given intramuscularly at interval of 3-6 weeks. Third injection of 1.0 cc. given 7 months after second. | Active | Not known (Salk has demonstrated adequate antibodies present after 8 years) | Booster dose of 1.0 cc. recommended 8 to 12 months after 3rd dose. Additional booster doses advised if in epidemic area. |

* Poliomyelitis Vaccine, oral, live, attenuated—These vaccines are licensed. No description is given in the table as their use is largely recommended for mass immunization. The Indiana State Medical Association, the Indiana State Health Officers Association and the Indiana State Board of Health in October 1962 stated there was little need for mass oral programs and recommended no new programs be initiated.

| Disease | Agent Used | Recommended For | Method of Administration | Type of Immunity | Duration of Protection | Booster Injection |
|---|---|---|---|---|---|---|
| Rabies | Rabies—hyperimmune serum 1000 units per pound of body weight Rabies Vaccine 7-14 doses | *Licks* of abraded skin or mucosa by proven rabid, suspicious, escaped, killed or unknown animal | Hyperimmune serum within 24-72 hours of exposure. Follow within 24 hours with Rabies Vaccine. | Passive immunity from hyperimmune serum | Few weeks | Repeat initial dose hyperimmune serum, but not after beginning Rabies Vaccine series as serum will block antibody production. |
| | | *Bites* of healthy animal, multiple, or face or head bites | Hyperimmune serum. Start vaccine but stop if animal remains normal for 3 days. | Active immunity from rabies vaccine | Indefinite | Rabies vaccine prepared according to Semple method—should not repeat full course—one to 3 injections probably sufficient. More hazardous Egg embryo vaccine—give one injection. |
| | | *Bite* of healthy animal, other than head or neck | No treatment. If animal becomes suspicious during 14 days observation give serum and vaccine at first suspicious signs. | | | |
| | | *Bites*—animal rabid, escaped, killed, unknown or any bites by any wild animal | Start treatment immediately, using hyperimmune serum followed by 7-14 doses vaccine, depending upon whether single or multiple bites and location. | | | |
| | | Bat bites and exposure to bats | Start treatment with Rabies Vaccine immediately without waiting for Laboratory Report. Bats are only animals known to occasionally survive rabies and remain carriers. | | | |
| Rocky Mountain Spotted Fever | Rocky Mountain Spotted Fever Vaccine | Not routinely recommended since advent of specific antibiotic therapy. May be used in areas of high incidence among persons of high risk. | Adults: 3 injections each 1.0 cc. subcutaneously or intramuscularly at intervals of one week. Children—under 10 years three injections each 0.5 cc. subcutaneously or intramuscularly at intervals of one week. | Active | One year | 1.0 cc. booster annually |
| Smallpox | Smallpox Vaccine (Vaccinia virus) | Children and adults | Begin at 5-12 months. Administered by multiple pressure technique skin over insertion of left deltoid. | Active | Indefinite, average 3 years | Repeat every 4th year. |

| | | | | | | |
|---|---|---|---|---|---|---|
| Tetanus | Tetanus Antitoxin | All cases of puncture wounds and animal bites when person has not been immunized or more than 2 years since last booster. | *Caution:* Skin test first for serum sensitivity. Intramuscular injection of 10,000 units antitoxin. | Passive | 10 days | Repeat with each injury. Because of hazard to horse serum active immunization with toxoid preferred. |
| Tetanus | Tetanus Toxoid, depot (alum precipitated or adsorbed) (See Double and Triple antigens under "Diphtheria") | All | Two doses, each 0.5 cc. given intramuscularly, at least one and preferably 2-3 months interval. | Active | At least 4 years | 0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured. |
| | Tetanus Toxoid, Fluid (See Double and Triple antigens under "Diphtheria") | All | Three doses, each 0.5 cc., subcutaneoulsy or intramuscularly at one month and preferably 2-3 months between doses. | Active | At least 4 years | 0.5 cc. end first year, then—booster every 2-4 years. Satisfactory recall response after 10 years but is too slow in case of injury. Emergency booster if injured. |
| Typhoid Fever | Typhoid Vaccine Triple vaccine containing 1000 million S. typhosa and 250 million each of paratyphoid A and B per cc. | All persons living in or traveling to areas where disease is endemic or insanitary conditions exist. | *Adults*<br>Three doses, each 0.5 cc. subcutaneously not less than 7 days or more than 28 day intervals between doses.<br>An alternate method is: 0.1 cc.; 0.15 cc. and 0.2 cc. given intradermally not less than 7 nor more than 28 days between doses.<br>*Children*<br>6 mo.-2 yr.—(1) 0.06 cc.; (2) 0.12 cc.; (3) 0.12 cc.<br>2 yr.- 6 yr.—(1) 0.12 cc.; (2) 0.25 cc.; (3) 0.25 cc.<br>6 yr.-10 yr.—(1) 0.25 cc.; (2) 0.50 cc.; (3) 0.50 cc. | Active | Indefinite—usually at least one year | Persons traveling or living in insanitary areas should receive booster of 0.1 cc. intradermally or 0.5 cc. subcutaneously annually. Children's annual booster the same dose as initial dose of each series. |
| Typhus Fever | Typhus Fever Vaccine | All persons traveling to or living in areas where epidemic typhus exists. | *Adults*<br>Two doses, each 1.0 cc. at intervals of 7-10 days given subcutaneously. Allergy to egg or chicken protein only contraindication.<br>*Children*<br>Three doses each:<br>6 mos.-2 yrs.: 0.12 cc.<br>2 yrs.- 6 yrs.: 0.25 cc.<br>6 yrs.-10 yrs.: 0.50 cc. | Active | Relative 3-6 months | *Adults*<br>Routine every 6 months dose of 1.0 cc. given subcutaneously or whenever threat of outbreak occurs.<br>*Children*<br>Same dose as in initial series. |

| Disease | Agent Used | Recommended For | Method of Administration | Type of Immunity | Duration of Protection | Booster Injection |
|---|---|---|---|---|---|---|
| Yellow Fever | Yellow Fever Vaccine* (Obtainable only at U. S. P. H. S. Hospital or Yellow Fever Immunization Depots. See footnote where obtainable in Indiana.) | All persons traveling in or through or living in endemic areas. Should receive vaccine 10 days before arrival in area. | One dose 0.5 cc. of a 1:10 dilution of concentrated vaccine, freshly prepared. Given subcutaneously. Should not be given to person ill with virus disease or at same time cowpox virus is given. Children's dose—same as adult. | Active | 6 years or longer | As required at present every 6 years repeat immunization. In presence of epidemic repeat primary immunization. |

*While many contraindications are listed for various biologicals it should be recognized that in the interest of brevity it was impossible to give all details. In case of doubt consult standard reference for detailed description of biological in question and/or pharmaceutical company's circular accompanying original package of biological.

*All* of the biologicals listed may be obtained through normal supply channels with the exception of Yellow Fever Vaccine. Because of hazards if yellow fever vaccine is improperly handled it can only be obtained from U. S. P. H. S. depots. In Indiana these depots are:

Indiana University Medical Center
1040 West Michigan Street
Indianapolis
Fridays, 11 a.m. to 12 noon CDT by appointment
Telephone: MElrose 5-8441, Ext. 441

Elkhart County Health Department
200 Harrison Street
Elkhart, Indiana
1st or 3rd Wednesday each month 2 p.m.
Telephone 26525

Physicians having patients requiring yellow fever immunization should advise person to call or write the above, as inoculations are given by appointment only on one day a week. There is a fee to cover vaccine and administration.

**(Revised)**

A. L. Marshall, Jr., M.D., *Director*
Division of Communicable Disease Control
Indiana State Board of Health ◄

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**AVAILABLE:** 1 mg. tablets. Bottles of 50 and 500.

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# Class A Narcotic Drugs

*The following is a compilation of Class A Narcotic Drugs by trade name, prepared for publication by the Indiana Pharmaceutical Association.*

| Package | Class A Narcotics by Trade Name |
|---|---|
| Tab. | Alvodine |
| Vial | Alvodine |
| Tab. | Amidone HCl. |
| Vial | Amidone HCl. |
| Tab. | A.P.C. Demerol (Demerol 30 mg.) |
| Supp. | B&O 15A (Opium ½ gr., Belladonna ¼ gr.) |
| Supp. | B&O 16A (Opium 1 gr., Belladonna ¼ gr.) |
| | Chlor-Anodyne (Morphine HCl. 2⅞ gr. per oz.) |
| | Cocaine Solutions |
| Solvets | Cocaine HCl. 2¼ gr. |
| Amp. | Codeine Phos. ½ gr. per cc. |
| H.T. | Codeine Phos. ¼ gr. |
| H.T. | Codeine Phos. ½ gr. |
| H.T. | Codeine Phos. 1 gr. |
| D.T. | Codeine Sulf. 1 gr. |
| H.T. | Codeine Sulf. ⅛ gr. |
| H.T. | Codeine Sulf. ¼ gr. |
| H.T. | Codeine Sulf. ½ gr. |
| H.T. | Codeine Sulf. 1 gr. |
| T.T. | Codeine Sulf. ¼ gr. |
| T.T. | Codeine Sulf. ½ gr. |
| T.T. | Codeine Sulf. 1 gr. |
| | Codeine, in combination, if more than 8 grs. per fl. oz. or more than 1 gr. per dosage unit |
| | Demerol Solutions |
| Amp. | Demerol 25 mg.—½ cc. |
| Amp. | Demerol 50 mg.—1 cc. |
| Amp. | Demerol 75 mg.—1½ cc. |
| Amp. | Demerol 100 mg. |
| Amp. | Demerol Atropine 2 cc. (Demerol 100 mg.—2 cc.) |
| Amp. | Demerol Scopolamine 2 cc. (Demerol 100 mg—2 cc.) |
| Elix. | Demerol (Demerol 50 mg. per 5 cc.) |
| | Demerol Disp. Syr. 50 mg.—1 cc. |
| | Demerol Disp. Syr. 75 mg.—1 cc. |
| | Demerol Disp. Syr. 100 mg.—1 cc. |
| Tab. | Demerol 50 mg. |
| Tab. | Demerol 100 mg. |
| Vial | Demerol 50 mg. per cc. |
| Vial | Demerol 100 mg. per cc. |
| Vial | Demerol Scopolamine (Demerol 50 mg. per cc.) |
| Tab. | Demerol APAP (Demerol 50 mg.) |
| Tab. | Demerol Comp. (Demerol 25 mg.) |
| Tab. | Demerol Lotusate (Demerol 100 mg.) |
| Tab. | Dicodid 5 mg. |
| Amp. | Dilaudid HCl. 1/32 gr.—1 cc. |
| Amp. | Dilaudid HCl. 1/20 gr.—1 cc. |
| Amp. | Dilaudid HCl. 1/16 gr.—1 cc. |
| Rect. Supp. | Dilaudid HCl. 1/20 gr. |
| Syr. | Dilaudid (1 mg.—5 cc.) |
| | Dilaudid HCl. Solutions |
| H.T. | Dilaudid HCl. 1/64 gr. |
| H.T. | Dilaudid HCl. 1/32 gr. |
| H.T. | Dilaudid HCl. 1/20 gr. |
| H.T. | Dilaudid HCl. 1/16 gr. |
| Vial | Dilaudid Sulf. 2 mg. per cc. |
| | Dionin Solutions |
| Amp. | Dolophine HCl. 10 mg.—1 cc. (Methadone HCl.) |
| 20 cc. Amp. | Dolophine HCl. 10 mg. per cc. |
| Syr. | Dolophine HCl. (Methadone HCl. 10 mg. per 30 cc.) |
| Tab. | Dolophine HCl. 5 mg. |
| Tab. | Dolophine HCl. 7.5 mg. |
| Tab. | Dolophine HCl. 10 mg. |
| Tab. | Donnagesic #2 (Codeine Phos. 1½ gr.) |
| | Dover's Po. N.F. (Po. Ipecac and Opium) |
| H.T. | H.M.C. #1 (Morphine HBr. ¼ gr.) |
| H.T. | H.M.C. #2 (Morphine HBr. ⅛ gr.) |
| | Hycodan Po. |
| 10 cc. Vial | Hymorphan HCl. 2 mg. per cc. |
| 10 cc. Vial | Hymorphan HCl. 2 mg. per cc. Atropine Sulf. 0.25 mg. per cc. |
| Amp. | Leritine 1 cc., 25 mg. per cc. |
| Amp. | Leritine 2 cc., 25 mg. per cc. |
| Tab. | Leritine 25 mg. |
| 30 cc. Vial | Leritine 25 mg. per cc. |
| Amp. | Levo-Dromoran 2 mg.—1 cc. |

| Package | Class A Narcotics by Trade Name |
|---|---|
| Tab. | Levo-Dromoran 2 mg. |
| 10 cc. Vial | Levo-Dromoran 2 mg. per cc. |
| Tubex | Meperidine HCl. 50 mg.—1 cc. |
| Tubex | Meperidine HCl. 75 mg.—1 cc. |
| Tubex M | Meperidine HCl. 100 mg.—1 cc. |
| Cap. | Mepergan |
| Cap. | Mepergan Fortis |
| Tubex | Mepergan 25—50 mg. per 2 cc. |
| 10 cc. Vial | Mepergan 25—25 mg.—1 cc. |
| Tubex | Mepergan 50—50 mg.—1 cc. |
| 10 cc. Vial | Mepergan 50—50 mg.—1 cc. |
| 100 Tab. | Mercodinone |
| 20 cc. Vial | Methadone HCl. 10 mg. per cc. |
| 30 cc. Vial | Methadone HCl. 10 mg. per cc. |
| Syr. | Methajade |
| | Morphine Acetate |
| Elix. | Morphine HCl. 1 gr. per fl. oz. |
| | Morphine Solutions |
| Amp. | Morphine Sulf. ¼ gr. per cc. |
| Amp. | Morphine Sulf. ¼ gr., Atropine Sulf. 1/150 gr. per cc. |
| H.T. | Morphine Sulf. ⅛ gr. |
| H.T. | Morphine Sulf. 1/6 gr. |
| H.T. | Morphine Sulf. ¼ gr. |
| H.T. | Morphine Sulf. ½ gr. |
| H.T. | Morphine Sulf. 1 gr. |
| H.T. | Morphine Sulf. ¼ gr., Atropine Sulf. 1/150 gr. |
| T.T. | Morphine Sulf. ¼ gr. |
| Amp. | Nisentil HCl. 40 mg.—1 cc. |
| Amp. | Nisentil HCl. 60 mg.—1 cc. |
| Vial | Nisentil HCl. 60 mg. per cc. |
| Tab. | Nodalin (Methadone HCl. 2.5 mg.) |
| Tab. | Nucodan 5 mg. |
| Amp. | Numorphan HCl. 1 cc. (1.5 mg. per cc.) |
| Amp. | Numorphan HCl. 2 cc. (1.5 mg. per cc.) |
| 10 cc. Vial | Numorphan HCl. (1.5 mg. per cc.) |
| Supp. | Numorphan HCl. 2 mg. |
| Tab. | Numorphan HCl. 10 mg. |
| Supp. | Numorphan HCl. 5 mg. |
| | Opium Po. |
| | Opium Po. Extract |
| Rect. Supp. | Opium 1 gr. Belladonna ¼ gr. |
| Tr. | Opium U.S.P. Deod. |
| | Pantopon All |
| | Papine |
| Cap. | Percobarb 5 mg. |
| Cap. | Percobarb-Demi 2.5 mg. |
| Tab. | Percodan 5 mg. |
| Tab. | Percodan-Demi 2.5 mg. |
| Amp. | Prinadol 2 mg. 1 cc. |
| 10 cc. Vial | Prinadol 2 mg. per cc. |
| Amp. | Spasmalgin 1 cc. (Pantopon 1/6 gr., Papaverine HCl. 1/3 gr., atropine sulfate 1/60 gr.) |
| Tab. | Spasmalgin (Pantopon 1/6 gr., Papaverine HCl. 1/3 gr., atropine sulfate 1/60 gr.) |

## *The Four Narcotic Classes*

Narcotics are divided in four classifications and are either taxable or exempt, depending upon the addictive quality, strength, form and the presence or absence of other ingredients. Taxable narcotics, **Class A and B,** may be dispensed only upon a prescription order issued by a physician, dentist, veterinarian or other practitioner duly registered under the provisions of the Federal Narcotic Law. Orders from practitioners for other than legitimate medical purposes are not considered valid prescription orders under Federal Law and both the prescriber and the pharmacist may incur criminal penalties for such a violation.

All prescription orders for **Class A Narcotics** must be dated and signed by the prescriber as of the date of issue and, in addition, must contain the full name and address of the patient and the full name, address and narcotic registry number of the prescriber. Narcotic prescription orders should be written in permanent form. Prescription orders for narcotics which have been placed in **Class B** must meet all of the requirements above except the prescriber may transmit his prescription order to the pharmacist orally. The pharmacist must reduce the oral prescription order to writing immediately and include the information required for Class A Narcotics but the prescriber's signature is not necessary.

Renewals of narcotic prescription orders

Continued

# LAKE LOTS FOR SALE

***Quiet, Fishing Lake***
**18 Acres—No Motors**

Amid the beauty of wooded hills in Morgan County—30 miles from Indianapolis — 5 miles from Martinsville, there's a beautiful, 18-acre lake dedicated to those who abhor internal combustion engines. This is a lake for those who love to fish and just look at the beauties of nature. The lake is 15 years old and full of fish native to Indiana. The water is clear and free of weeds.



## SPECIAL DISCOUNT ON LAKE LOTS

To those planning to build a Timber Lodge immediately

Plan now to see the 2-bedroom Timber Lodge (928 sq. ft.) display model on exhibit at Lahr Lake. This building with its country kitchen and open 12' x 24' covered porch is offered for sale now.

For full information call
Fred W. Lahr, President

**Timber Lodge**

**ME 5-5328**

**See Timber Lodge Display Mon. thru Fri. —9 a.m. to 5 p.m. By appointment anytime • 915 N. Pennsylvania St., Indianapolis**

**Special to Doctors:**

This is my own private lake. I maintain a full-time caretaker who lives on the place. Each water-front lot is roughly one acre — not more than 20 lots will be sold. This will give you the highest pro rata share of water of any lake that I know of — and the maximum in peaceful, restful living. It's a hide-away for those who seek rest and quiet.


## NARCOTIC CLASSES

Continued

are prohibited, except as to exempt preparations. **Class X preparations** are regulated as to narcotic content and must, in addition, contain one or more non-narcotic active medicinal ingredients in therapeutic amounts. Class X narcotic preparations may be procured without an official order form. The pharmacist maintains a required record showing the name of the recipient, his address, the name and quantity of the Class X preparation and the date of delivery.

**Class M preparations** may contain any quantity of the specified drug with either active or inactive non-narcotic ingredients commonly used in medicinal preparations. The pharmacist is not required to maintain a record of dispositions of Class M preparations because such preparations have been found to have little or no additive properties. Examples of narcotic drugs which, when found in combination with non-narcotic ingredients are included in Class M include narcotine, papaverine, narceine and cotarnine. ◄



**I've been reading this medical magazine in your waiting room, doctor, and I find I've got every ailment in it!**

(One of a series of ads being used in key Hoosier newspapers)

# "I don't know what we would have done without Blue Cross Blue Shield."



Baby's well and happy . . . the bills are all paid . . . and many a new parent has made the same, thankful comment: "I don't know what we would have done without Blue Cross–Blue Shield."

For, Blue Cross–Blue Shield just steps in and takes over the health care financial problems. Realistic benefits are provided at the hospital, generous allowances made to your physician.

Blue Cross–Blue Shield takes over for the employer, too—cuts paperwork to a minimum, eliminates red tape, saves administrative time. If you want to join, phone the nearest Blue Cross–Blue Shield office for more information.

**BLUE CROSS - BLUE SHIELD**

MUTUAL HOSPITAL INSURANCE, INC. MUTUAL MEDICAL INSURANCE, INC.
HOME OFFICE: 110 N. ILLINOIS ST., INDIANAPOLIS 9, INDIANA

# Deaths of Indiana Physicians in 1964

*Compiled by James B. Maple, M.D., Necrologist*

(M) Member ISMA, (S) Senior Member, (R) Retired

| Name | Age | Date of Death | Address | Cause of death |
|---|---|---|---|---|
| Walker, William F. (M) | 34 | Jan. 1 | Evansville | Acute cerebellar hemorrhage. |
| Kleinman, Francis J. (S) | 76 | Jan. 5 | Hebron | Carcinoma of the rectum with metastasis. |
| Wood, Joseph J. | 79 | Jan. 5 | Portage | Hypostatic pneumonia. |
| Robrock, Lawrence A. | 72 | Jan. 8 | Michigan City | Acute coronary occlusion. Arteriosclerotic heart disease. |
| Smith, Lawson F. | 57 | Jan. 9 | Indianapolis | Coronary occlusion. Arteriosclerotic heart disease. |
| May, George A. (M) | 60 | Jan. 9 | Madison | Acute congestive heart failure. |
| Lewis, Lawrence A. | 75 | Jan. 10 | Indianapolis | Cerebral thrombosis. |
| Keenan, Reid L. (M) | 61 | Jan. 17 | Indianapolis | Addison's crisis. Addison's disease. |
| Kokomoor, Henry A. | 85 | Jan. 26 | Evansville | Arteriosclerotic cardiovascular disease. |
| Braunlin, Robert F. (M) | 67 | Feb. 3 | Marion | Adenocarcinoma of the abdomen. |
| Harold, Albert H. (S) (R) | 86 | Feb. 5 | Zionsville | Malignant tumor of the prostate. |
| Geronimo, Manuel M. (M) | 56 | Feb. 9 | East Chicago | Coronary thrombosis. |
| Oliphant, Wilmer G. (M) | 49 | Feb. 10 | Terre Haute | Hemorrhagic duodenal ulcer. |
| Van Nuys, John D. (M) | 56 | Feb. 15 | Indianapolis | Myocardial infarction, hypertension. |
| Bishop, Robert E. | 52 | Feb. 16 | Pierceton | Carcinoma. |
| Blosser, Howard V. (S) | 91 | Feb. 16 | Ft. Wayne | Pulmonary tuberculosis. |
| Fleming, Claude F. (S) | 83 | Feb. 20 | Elkhart | Arteriosclerotic kidney. |
| Hanna, Bertram L. | 39 | Feb. 23 | Indianapolis | Cardiac arrhythmia, arteriosclerotic heart disease. Diabetes mellitus. |
| Owens, Thomas R. (S) | 72 | Feb. 27 | Muncie | Carcinoma of the prostate. |
| Netherton, Clyde R. (S) | 84 | Mar. 2 | Chalmers | Congestive heart failure. Generalized arteriosclerosis. |
| Kearney, William W. | 51 | Mar. 3 | New Castle | Bronchopneumonia. Laennec's cirrhosis. Diabetes mellitus. |
| McCord, Carl B. (S) | 80 | Mar. 5 | Veedersburg | Asphyxiation from smoke inhalation. Third degree burns over entire body. |
| Jones, John G. (S) | 88 | Mar. 12 | Vincennes | Cardiovascular accident. |
| Reck, John L. (S) | 81 | Mar. 13 | Sheridan | Acute anemia. Intraabdominal hemorrhage. |
| Beck, Herma A. (S) (R) | 83 | Mar. 13 | Lebanon | Uremia. Carcinoma of the colon. C.V.R.D. |
| Wilson, Leslie (M) | 63 | Mar. 16 | Ft. Wayne | Myocardial infarction. |
| Strickland, Karl S. (S) | 83 | Mar. 17 | Owensville | Cerebral hemorrhage. Hypertensive vascular disease. |
| Casey, John B. | 64 | Mar. 21 | Indianapolis | Carcinoma of the stomach. |
| Bond, S. Edgar | 88 | Mar. 22 | Webster | Obstructive jaundice. Possible carcinoma of the pancreas. |
| Robinson, Bruce B. | 72 | Mar. 24 | Culver | Arteriosclerosis. |
| Zierer, Reuben O. (M) | 63 | Mar. 31 | Rockville | Arteriosclerotic heart disease. |
| Marshall, George L. (S) | 82 | Apr. 2 | Bourbon | Aneurysm, abdominal aorta, arteriosclerosis. |
| Smith, Willard O. | 86 | Apr. 12 | Hoagland | Coronary artery occlusion. Arteriosclerosis. |
| Spohn, Edward A. | 83 | Apr. 15 | Walton | Non-alcoholic cirrhosis of the liver. Leukemia. |
| Smith, Rodney D. (S) | 95 | Apr. 23 | Bloomington | Cerebral thrombosis. Generalized arteriosclerosis. |
| Heinrichs, Harry H. (S) (R) | 83 | Apr. 26 | Indianapolis | Acute myocardial infarction. Coronary artery disease. |
| Siebenmorgen, Louis (S) | 77 | Apr. 28 | Terre Haute | Metastatic carcinoma, primary common bile duct. Coronary heart disease. |
| Scamahorn, Oscar T. (S) | 80 | Apr. 29 | Pittsboro | Pulmonary edema. Arteriosclerotic heart disease. |

| Name | Age | Date of Death | Address | Cause of death |
|---|---|---|---|---|
| Dare, Lee A. (M) | 55 | May 3 | Jeffersonville | Myocardial infarction. Coronary artery disease. Diabetes mellitus. |
| Stroup, Tyler J. (M) | 59 | May 5 | Indianapolis | Cardiovascular accident. |
| Pandolfo, Harry (M) | 56 | May 5 | Indianapolis | Hepatic insufficiency. Giant follicular cell sarcoma. |
| Sorenson, Raymond (M) | 60 | May 8 | Kokomo | Coronary thrombosis. |
| Daggy, Benjamin T. (M) | 78 | May 8 | Richmond | Amyotropic lateral sclerosis. |
| Schenck, Foss (S) | 83 | May 15 | Logansport | Myocardial infarction. |
| Prenatt, Francis (M) | 69 | May 16 | Madison | Viral hepatitis. |
| Merrell, Paul (M) | 64 | May 20 | Indianapolis | Agranulocytosis. |
| Shenk, Earl M. (S) | 78 | May 26 | Kokomo | Bronchogenic carcinoma. |
| Little, John W. (S) | 91 | May 29 | Indianapolis | Cerebrovascular thrombosis. |
| Lingeman, Roger E. (M) | 48 | June 2 | Indianapolis | Gastrointestinal hemorrhage. Portal cirrhosis. |
| Nolt, Ernest V. (S) | 80 | June 2 | Columbus City | Coronary thrombosis. Coronary arteriosclerosis. |
| Phelps, William J. (M) | 36 | June 2 | Ft. Wayne | Acute myocarditis. |
| Edmonds, Charles W. | 80 | June 12 | Richmond | Bronchopneumonia. Arteriosclerotic heart disease. |
| Gray, Clyde C. (S) | 82 | June 12 | Cloverdale | Bilateral occlusion of femoral arteries. Generalized arteriosclerosis. |
| Yoder, Mary J. | 25 | June 13 | Middlebury | Auto accident. |
| Province, Oran A. (M) | 87 | June 14 | Franklin | Arteriosclerotic heart disease. Bronchopneumonia. |
| Carter, Oren E. (M) | 69 | June 20 | Indianapolis | Metastatic carcinoma of the lung. |

Continued

WABASH VALLEY HOSPITAL
"On the Banks of the Wabash"




A hospital for the treatment of Neuro Psychiatric Disorders
Open Psychiatric and consulting staff

DONALD R. KINZER, Administrator
West Lafayette, Indiana Phone Ri. 3-3841

| Name | Age | Date of Death | Address | Cause of death |
|---|---|---|---|---|
| Cartwright, Jack D. (M) | 46 | June 22 | La Porte | Pneumonia. Rheumatoid arthritis. |
| Omstead, Trevalyn W. (M) | 64 | June 23 | Fort Wayne | Cerebral thrombosis with infarction. |
| Casebeer, Paul B. | 66 | June 25 | Clinton | Ruptured thoracic aortic aneurysm. |
| Wood, Charles R. | 84 | June 27 | Gary | Arteriosclerotic heart disease. |
| Pebworth, Aubrey C. (S) | 86 | July 3 | Indianapolis | Bronchopneumonia. |
| Stone, Benson W. | 29 | July 7 | Peru | Auto accident. |
| Mackey, Harry S. (S) | 87 | July 9 | Rochester | Coronary occlusion. |
| Hughes, Lawrence M. | 62 | July 10 | Martinsville | Acute cardiac dilatation. Hypertension. Diabetes mellitus. |
| Heller, Nelson L. (S) | 78 | July 10 | Dunkirk | Arteriosclerotic heart disease. |
| Lumm, Arthur B., Jr. | 29 | July 10 | Wabash | Drowned. |
| Ross, Harry P. (M) (R) | 65 | July 18 | Richmond | Arteriosclerotic coronary heart disease. |
| Eades, Ralph C. (M) | 63 | July 19 | Valparaiso | Hepatoma with metastasis. |
| Kelly, John F. | 64 | Aug. 22 | Marion | Overdose of barbiturates. |
| Funkhouser, Elmer (S) | 79 | Aug. 23 | Indianapolis | Myocardial infarction. Cardiac arrest. |
| Ditton, Irvin W. (S) | 92 | Aug. 28 | Fort Wayne | Arteriosclerotic heart disease. |
| Rupel, Ernest (S) | 72 | Sept. 1 | Indianapolis | Hypostatic pneumonia. Myocardial insufficiency. |
| Neal, William H. | 87 | Sept. 2 | Muncie | Arteriosclerotic heart disease. |
| Phillips, John R. | 65 | Sept. 4 | Indianapolis | Pneumonia. Congestive heart failure. |
| Haslinger, Clarence J. (M) | 60 | Sept. 10 | Indianapolis | Multiple myeloma. |
| Martin, Guy (M) | 65 | Sept. 22 | Seymour | Anoxia. Ventricular fibrillation. Arteriosclerosis. |
| Barton, Alva G., Jr. | 39 | Sept. 27 | Jeffersonville | Bullet wound in left chest. |
| Weller, Charles A. (S) (R) | 78 | Oct. 5 | Indianapolis | Acute renal failure. Ruptured gallbladder. Cholelithiasis. |
| Blessinger, Paul J. (M) | 69 | Oct. 6 | Jasper | Cardiovascular accident. Hypertensive arteriovascular disease. |
| Adams, Daniel S. (S) | 88 | Oct. 10 | Indianapolis | Intestinal obstruction. |
| Poston, Clement L. (M) | 64 | Oct. 14 | Laurel | Coronary thrombosis. |
| King, William E. (M) | 65 | Oct. 15 | Indianapolis | Acute coronary occlusion. |
| Uregdy-Nagy, Joseph (R) | 69 | Oct. 21 | Lafayette | Cerebral thrombosis. |
| LaBier, Clarence R. (S) | 91 | Oct. 24 | Terre Haute | Bronchopneumonia. Carcinomatosis. |
| Williams, Alice D. | 95 | Oct. 27 | Marion | Arteriosclerotic heart disease. |
| Knight, Orville E. (R) | 57 | Nov. 2 | Warren | Massive intestinal hemorrhage. |
| Orders, Clark E. (S) | 85 | Nov. 5 | Speedway | Pulmonary edema. Cardiac failure. Diabetes mellitus. |
| Atkinson, Norman E. (R) | 92 | Nov. 9 | Petersburg | Myocardial infarction. Arteriosclerotic heart disease. |
| Kennedy, Eva N. (S) | 82 | Nov. 12 | Camden | Subdural hemorrhage. |
| Allen, Orris T. (S) | 85 | Nov. 14 | Terre Haute | Cerebral hemorrhage. Cerebral arteriosclerosis. |
| Hooke, Sam W. (S) | 79 | Nov. 28 | Noblesville | Acute coronary occlusion. Coronary artery disease. |
| Boyd, Charles S. (M) | 65 | Nov 29 | East Chicago | Cerebrovascular hemorrhage. |
| Bradley, Stephen C. (S) | 83 | Dec. 4 | Terre Haute | Cerebrovascular accident. Arteriosclerotic heart disease. |
| McConnell, James F. | 43 | Dec. 4 | Evansville | Peritonitis. Bowel perforation. Periarteritis nodosa. |
| Hodges, Fletcher (S) (R) | 86 | Dec. 5 | Indianapolis | Congestive heart failure. Arteriosclerotic heart disease. |
| Dielman, Franklin C. (S) | 85 | Dec. 10 | Fulton | Coronary occlusion. Postoperative strangulated hernia. |
| Kennedy, John T. | 78 | Dec. 14 | Indianapolis | Bilateral bronchopneumonia. Arteriosclerotic heart disease. |
| Van Dyke, George H. | 101 | Dec. 17 | Winona Lake | Cardiovascular renal failure. |
| Stamets, Zeanith H. | 93 | Dec. 22 | Fort Wayne | Glomerulonephritis. Senility. |
| Daniels, George R. (S) | 86 | Dec. 28 | Marion | Cerebral arteriosclerosis. |
| Hauss, Augustus P. (S) | 75 | Dec. 30 | New Albany | Carcinoma of left lung. ◄ |

# Presidents of ISMA Since Its Organization

| Medical Convention | Elected | Served |
|---|---|---|
| *Livingston Dunlap, Indianapolis | 1849 | 1849 |
| **Medical Society** | | |
| *William T. S. Cornett, Versailles | 1849 | 1850 |
| *Ashahel Clapp, New Albany | 1850 | 1851 |
| *George W. Mears, Indianapolis | 1851 | 1852 |
| *Jeremiah H. Brower, Lawrenceburg | 1852 | 1853 |
| *Elizur H. Deming, Lafayette | 1853 | 1854 |
| *Madison J. Bray, Evansville | 1854 | 1855 |
| *William Lomax, Marion | 1855 | 1856 |
| *Daniel Meeker, LaPorte | 1856 | 1857 |
| *Talbot Bullard, Indianapolis | 1857 | 1858 |
| *Nathan Johnson, Cambridge City | 1858 | 1859 |
| *David Hutchinson, Mooresville | 1859 | 1860 |
| *Benjamin S. Woodworth, Ft. Wayne | 1860 | 1861 |
| *Theophilus Parvin, Indianapolis | 1861 | 1862 |
| *James F. Hibberd, Richmond | 1862 | 1863 |
| *John Sloan, New Albany | 1863 | ---- |
| *John Moffet (acting), Rushville | 1863 | 1864 |
| *Samuel L. Linton, Columbus | 1864 | ---- |
| *Wilson Lockhart (acting), Danville | 1864 | 1865 |
| *Myron H. Harding, Lawrenceburg | 1865 | 1866 |
| *Vierling Kersey, Richmond | 1866 | 1867 |
| *John S. Bobbs, Indianapolis | 1867 | 1868 |
| *Nathaniel Field, Jeffersonville | 1868 | 1869 |
| *George Sutton, Aurora | 1869 | 1870 |
| *Robert N. Todd, Indianapolis | 1870 | 1871 |
| *Henry P. Ayres, Ft. Wayne | 1871 | 1872 |
| *Joel Pennington, Milton | 1872 | 1873 |
| *Isaac Casselberry, Evansville | 1873 | ---- |
| *Wilson Hobbs (acting), Knightstown | 1873 | 1874 |
| *Richard E. Houghton, Richmond | 1874 | 1875 |
| *John H. Helm, Peru | 1875 | 1876 |
| *Samuel S. Boyd, Dublin | 1876 | 1877 |
| *Luther D. Waterman, Indianapolis | 1877 | 1878 |
| *Louis Humphreys, South Bend | 1878 | ---- |
| *Benj. Newland (acting), Bedford (v.p.) | 1878 | 1879 |
| *Jacob R. Weist, Richmond | 1879 | 1880 |
| *Thomas B. Harvey, Indianapolis | 1880 | 1881 |
| *Marshall Sexton, Rushville | 1881 | 1882 |
| *William H. Bell, Logansport | 1882 | 1883 |
| *Samuel E. Mumford, Princeton | 1883 | 1884 |
| *James H. Woodburn, Indianapolis | 1884 | 1885 |
| *James S. Gregg, Ft. Wayne | 1885 | 1886 |
| *General W. H. Kemper, Muncie | 1886 | 1887 |
| *Samuel H. Charlton, Seymour | 1887 | 1888 |
| *William H. Wishard, Indianapolis | 1888 | 1889 |
| *James D. Gatch, Lawrenceburg | 1889 | 1890 |
| *Gonsolvo C. Smythe, Greencastle | 1890 | 1891 |
| *Edwin Walker, Evansville | 1891 | 1892 |
| *George F. Beasley, Lafayette | 1892 | 1893 |
| *Charles A. Daugherty, South Bend | 1893 | 1894 |
| *Elijah S. Elder, Indianapolis | 1894 | ---- |
| *Charles S. Bond (acting), Richmond | 1894 | 1895 |
| *Miles F. Porter, Ft. Wayne | 1895 | 1896 |
| *James H. Ford, Wabash | 1896 | 1897 |
| *William N. Wishard, Indianapolis | 1897 | 1898 |
| *John C. Sexton, Rushville | 1898 | 1899 |

| Medical Society | Elected | Served |
|---|---|---|
| *Walker Schell, Terre Haute | 1899 | 1900 |
| *George W. McCaskey, Ft. Wayne | 1900 | 1901 |
| *Alembert W. Brayton, Indianapolis | 1901 | 1902 |
| *John B. Berteling, South Bend | 1902 | 1903 |
| *Jonas Stewart, Anderson | 1903 | 1904 |
| *George T. MacCoy, Columbus | 1904 | 1905 |
| *George H. Grant, Richmond | 1905 | 1906 |
| *George J. Cook, Indianapolis | 1906 | 1907 |
| *David C. Peyton, Jeffersonville | 1907 | 1908 |
| *George D. Kahlo, French Lick | 1908 | 1909 |
| *Thomas C. Kennedy, Shelbyville | 1909 | 1910 |
| *Frederick C. Heath, Indianapolis | 1910 | 1911 |
| *William F. Howat, Hammond | 1911 | 1912 |
| *A. C. Kimberlin, Indianapolis | 1912 | 1913 |
| *John P. Salb, Jasper | 1913 | 1914 |
| *Frank B. Wynn, Indianapolis | 1914 | 1915 |
| *George F. Keiper, Lafayette | 1915 | 1916 |
| *John H. Oliver, Indianapolis | 1916 | 1917 |
| *Joseph Rilus Eastman, Indianapolis | 1917 | 1918 |
| *William H. Stemm, North Vernon | 1918 | 1919 |
| *Charles H. McCully, Logansport | 1919 | 1920 |
| *David Ross, Indianapolis | 1920 | 1921 |
| *William R. Davidson, Evansville | 1921 | 1922 |
| *Charles H. Good, Huntington | 1922 | 1923 |
| *Samuel E. Earp, Indianapolis | 1923 | 1924 |
| *Eldridge M. Shanklin, Hammond | 1924 | 1925 |
| **Medical Association** | | |
| *Charles N. Combs, Terre Haute | 1925 | 1926 |
| *Frank W. Cregor, Indianapolis | 1926 | 1927 |
| *George R. Daniels, Marion | 1926 | 1928 |
| *Charles E. Gillespie, Seymour | 1927 | 1929 |
| *Angus C. McDonald, Warsaw | 1928 | 1930 |
| *Alois B. Graham, Indianapolis | 1929 | 1931 |
| Franklin S. Crockett, Lafayette | 1930 | 1932 |
| *Joseph H. Weinstein, Terre Haute | 1931 | 1933 |
| *Everett E. Padgett, Indianapolis | 1932 | 1934 |
| *Walter J. Leach, New Albany | 1933 | 1935 |
| *Roscoe L. Sensenich, South Bend | 1934 | 1936 |
| *Edmund D. Clark, Indianapolis | 1935 | 1937 |
| Herman M. Baker, Evansville | 1936 | 1938 |
| *Edmund M. Van Buskirk, Ft. Wayne | 1937 | 1939 |
| Karl R. Ruddell, Indianapolis | 1938 | 1940 |
| *Albert M. Mitchell, Terre Haute | 1939 | 1941 |
| Maynard A. Austin, Anderson | 1940 | 1942 |
| *Carl H. McCaskey, Indianapolis | 1941 | 1943 |
| *Jacob T. Oliphant, Farmersburg | 1942 | 1944 |
| *Nelsen K. Forster, Hammond | 1943 | 1945 |
| *Jesse E. Ferrell, Fortville | 1944 | 1946 |
| *Floyd T. Romberger, Lafayette | 1945 | 1947 |
| *Cleon A. Nafe, Indianapolis | 1946 | 1948 |
| *Augustus P. Hauss, New Albany | 1947 | 1949 |
| *C. S. Black, Warren | 1948 | 1950 |
| *Alfred Ellison, South Bend | 1949 | 1951 |
| *J. William Wright, Indianapolis | 1950 | 1952 |
| Paul D. Crimm, Evansville | 1951 | 1953 |
| Wm. Harry Howard, Hammond | 1952 | 1954 |
| *Walter L. Portteus, Franklin | 1953 | 1955 |

* Deceased.

## ISMA PRESIDENTS

Continued

| Medical Association | Elected | Served |
|---|---|---|
| Walter U. Kennedy, New Castle | 1954 | 1956 |
| Elton R. Clarke, Kokomo | 1955 | 1957 |
| M. C. Topping, Terre Haute | 1956 | 1958 |
| Kenneth L. Olson, South Bend | 1957 | 1959 |
| Earl W. Mericle, Indianapolis | 1958 | 1960 |
| Guy A. Owsley, Hartford City | 1959 | 1961 |
| *Harry R. Stimson, Gary | 1960 | 1962 |
| Maurice E. Glock | 1961 | 1963 |
| Donald E. Wood | 1962 | 1964 |

* Deceased.

### Type E Botulism Antitoxin

The Public Health Service is stockpiling antitoxin to be reserved for use against type E botulism. It will be stored at PHS Communicable Disease Center, Atlanta, Georgia, which will be on 24-hour call for emergency use.

**The CDC emergency number is Area Code 404, telephone 634-2561.**



I wonder if our Blue Cross covers this!


# Hygroton®

**brand of chlorthalidone**

**the long-acting diuretic**

**Indications:** Many types of edema involving retention of salt and water.
**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.
**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
**Average Dosage:** One tablet (100 mg.) daily with breakfast.
**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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Hygroton, brand of chlorthalidone, gets rid of edema efficiently. Your edematous patients will generally need far fewer tablets than with most diuretics. And they'll generally save more on prescription costs. One tablet a day is a popular dosage. So is one tablet every other day. You may even find half a tablet three times a week does the job. No other diuretic works as long. And none has as much natruretic activity per tablet.* For good riddance of edema with the least number of tablets, prescribe Hygroton, brand of chlorthalidone.

**Hygroton®** brand of chlorthalidone

**Geigy**

# Constitution and Bylaws of the Indiana State Medical Association

## CONSTITUTION

### ARTICLE I.—NAME OF THE ASSOCIATION

The name and title of this organization shall be the Indiana State Medical Association.

### ARTICLE II.—PURPOSE OF THE ASSOCIATION

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the State of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly intercourse among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care, and public health, so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

### ARTICLE III.—COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Association.

### ARTICLE IV.—COMPOSITION OF THE ASSOCIATION

Section 1.—This Association shall consist of Active Members, Associate Members, Senior Members and Honorary Members.

Sec. 2.—*Active Members.*—The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the Indiana State Medical Association.

Sec. 3.—*Associate Members.*—Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.

Sec. 4.—*Senior Members.*—Senior members shall be physicians of the State of Indiana who have attained the age of seventy years and have held membership in the Indiana State Medical Association for twenty years or more, and who, upon their application, have been certified to the Executive Secretary as eligible for such membership by the county societies of which they are members. Eligibility to senior status shall begin the year after the member reaches the age of seventy.

Sec. 5.—*Honorary Members.*—Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Sec. 6.—*Rights and Privileges of Members*—Active members and senior members shall have the same rights and privileges except as follows:

a. Senior members shall not be required to pay membership dues in the State Association.

b. If senior members desire to receive THE JOURNAL of the State Association, they shall pay the regular subscription price therefor.

c. Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XXIX of the Bylaws for this coverage.

d. Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold office. They shall not be required to pay membership dues in the State Association.

### ARTICLE V.—HOUSE OF DELEGATES

The House of Delegates shall be the legislative and business body of the Association and shall consist of (1) Delegates elected by the component county societies; (2) the Councilors; and (3) the ex-presidents of the Indiana State Medical Association. The following shall be *ex officio* members: the President, the President-elect, the Executive Secretary, the Treasurer and Assistant Treasurer of this Association, and the delegates to the American Medical Association, all without power to vote, except in case of a tie vote, when the President or person presiding shall cast the deciding vote.

### ARTICLE VI.—COUNCIL

The Council shall consist of (1) the Councilors, and (2) *ex officio* the President, President-elect, Treasurer with power to vote and Assistant Treasurer without power to vote except in case the Treasurer be absent. Besides its duties mentioned in the Bylaws, it shall constitute the Board of

Trustees of this organization, having full charge and control of all the property of the Association. It shall have full authority and power of the House of Delegates between sessions of the House of Delegates, except that it shall not make changes in the laws governing the Association nor exercise legislative functions, except as stated in the By-laws, and at all times shall be the finance committee of the Association. Seven Councilors shall constitute a quorum.

### ARTICLE VII.—SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Councilor District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Councilor districts shall be defined by the House of Delegates.

### ARTICLE VIII.—CONVENTION AND MEETINGS

Section 1.—The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Sec. 2.—The House of Delegates shall select the place five years in advance for holding the Annual Convention. The time for the convention shall be fixed by the Council, and the Council shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Sec. 3.—Special meetings of either the Association or the House of Delegates shall be called by the President on petition of twenty delegates or fifty members. Upon receipt by the president of such a petition of twenty delegates, or fifty members, the president shall within 30 days thereafter issue a call for such special meeting at a time and place to be fixed by the president. The president, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made.

### ARTICLE IX.—OFFICERS

Section 1.—The officers of this Association shall be a President, a President-elect, an Executive Secretary, a Treasurer, an Assistant Treasurer and thirteen Councilors, each of whom shall be a member, except the Executive Secretary, who need not necessarily be either a physician or a member.

Sec. 2.—The officers, except the Councilors and the Executive Secretary, whose election has been provided for hereinafter, shall be elected annually. The terms of elected Councilors shall be for three years and approximately one-third of the number shall be elected annually. No Councilor shall be eligible to serve longer than two consecutive three-year terms, effective with the beginning of his next election following the adoption of this amendment.

All of these officers shall serve until their successors are elected and installed. Provided, that if any elected Councilor fails, without reason acceptable to the Council, in any one calendar year to attend a majority of the meetings of the Council, he shall thereby cease to be a Councilor, and the Executive Secretary shall thereupon take action in accordance with Section 4 of this article.

Sec. 3.—The officers of this Association with the exception of the Executive Secretary shall be elected by the House of Delegates as the first order of business at the final meeting of the House of Delegates, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

Sec. 4.—The Councilors shall be elected by the respective district societies. If any district fails to meet and elect its Councilor by the time of expiration of the incumbent's term of office, the Executive Secretary of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Sec. 5.—Each Councilor district shall elect an alternate Councilor whose term of office shall be the same as the Councilor, namely three years. The alternate Councilor shall be elected in a year during which there is no Councilor elected.

The duties of the alternate Councilor shall be:

1. To represent the Councilor district in the absence of the regularly elected Councilor.

2. To vote only in the absence of the regularly elected Councilor either in the House of Delegates or in Council meetings where he represents the regularly elected Councilor.

3. The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present.

Sec. 6.—Any officer may be removed from office after a hearing before the Council, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Council.

Sec. 7.—In event of the death, resignation, removal, or disability of the President, the President-elect shall succeed to the presidency. In the event of the death, disability, resignation or removal of both the President and the President-elect, the chairman of the Council shall become President pro tem and as such shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-elect shall be elected, both of whom shall take office immediately upon their election.

Sec. 8.—A vacancy in the office of Treasurer or Assistant Treasurer shall be filled by an election by the Councilors at the next regular meeting of the Council following the occurrence of such vacancy.

Sec. 9.—In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any district councilor, the duly elected alternate councilor from the same district shall succeed to the office of councilor in that district for the unexpired term of said councilor.

In the event vacancies occur in any councilor district in the offices of both councilor and alternate councilor, the vacancies shall be filled by an election by the members of the association within the councilor district in which such vacancies occur. A call for such elections shall be issued by the Executive Secretary of the State Association following conference with the officers of the district organization. The call shall state the time and place of holding the election and shall be sent registered mail to the county secretary as filed in the State secretary's office of each component society within the district. Such call shall be mailed within ten days after the State secretary has learned of the vacancies. The election may be held at a special or regular meeting in which other business than the election may be transacted. Such election shall be held within fifteen days after the secretary of the State Association shall have mailed such call.

Sec. 10.—None of the officers shall receive compensation except the Executive Secretary, who shall be employed by the Council, and the Council shall fill any vacancy in that office.

### ARTICLE X.—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of re-election.

### ARTICLE XI.—INCOME AND EXPENSES

Funds for carrying on the activities of this Association shall be raised by the following means:

a. Membership dues to be collected by the component county societies in connection with the dues for such component societies. The amount of the dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

b. Voluntary contributions.

c. Revenues derived from the Association's publications.

d. Any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Executive Committee and Council for approval before final action is taken thereon.

### ARTICLE XII.—REFERENDUM

Section 1.—A General Meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

Sec. 2.—The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

### ARTICLE XIII.—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

### ARTICLE XIV.—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in THE JOURNAL of this Association.

## BYLAWS

### CHAPTER I.—MEMBERSHIP

Section 1.—The term "Member" as used in these Bylaws unless otherwise indicated shall mean both active and senior members of component county medical societies who hold either the Degree of Doctor of Medicine or Bachelor of Medicine.

Sec. 2.—Any physician who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Sec. 3.—No person whose license to practice medi-

cine has been suspended or revoked or who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this association or of a component county society, nor shall he be permitted to take part in any of their proceedings until he has been relieved of such disability.

Sec. 4.—Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

## CHAPTER II.—GENERAL MEETINGS

Section 1.—General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers.

Sec. 2.—The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Sec. 3.—All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive Secretary when read.

Sec. 4.—The Council shall appropriate from the funds of the Association for such an amount as in the discretion of the Council shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

## CHAPTER III.—SECTIONS

Section 1.—During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical.
b. Internal Medicine.
c. Eye, Ear, Nose, and Throat.
d. Anesthesia.
e. General Practice.
f. Obstetrics and Gynecology.
g. Preventive Medicine and Public Health.
h. Radiology.
i. Nervous and Mental Diseases.
j. Pathology.
k. Any other sections that hereafter may be provided for by the House of Delegates.

Sec. 2.—The officers of each section shall be a Chairman, a Vice-Chairman, and a Secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Sec. 3.—The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Sec. 4.—No section meeting shall be allowed to conflict with a general meeting.

## CHAPTER IV.—HOUSE OF DELEGATES

Section 1.—The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the General or Section Meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program.

Sec. 2.—Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county.

The number of Delegates to which each Component Society is entitled shall be based upon the number of members on record in the office of the Executive Secretary in good standing with current dues fully paid as of December 31 of the preceding year.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive Secretary of this Association on or before February first prior to the Annual

Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credentials as a delegate or alternate, properly signed by the secretary of his county society, be presented to the Committee on Credentials at the time of the Annual Convention.

Sec. 3.—Fifty delegates shall constitute a quorum.

Sec. 4.—The House of Delegates shall:

a. Elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

b. Divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

c. Have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

d. Approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 5.—Proposals calling for appropriations of funds by the House of Delegates shall be submitted to the Executive Committee and the Council for their recommendation before final action of the House.

Sec. 6.—At the first meeting the President shall announce the membership of the reference committees, as hereinafter provided for, and any other committees considered by him necessary to expedite the business of the Association.

Sec. 7.—All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive Secretary of the Association so that he will receive them not later than forty-five days prior to the meeting of the House of Delegates to which the resolutions will be presented for action.

Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Sec. 8.—The final vote on any issue calling for changes in dues or in dues structure or any changes in the Constitution and Bylaws shall be by roll call vote. Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote of such an issue.

## CHAPTER V.—ELECTION OF OFFICERS

Section 1.—The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

Sec. 2.—All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

Sec. 3.—Any person known to have solicited votes for or sought any office within the gift of this Association shall be ineligible for any office for two years

Sec. 4.—The President, President-elect, Treasurer and Assistant Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect, Treasurer and Assistant Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

## CHAPTER VI.—DUTIES OF OFFICERS

Section 1.—The president, or a member designated by him, shall preside at all general meetings of the Association and of the House of Delegates. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Councilors in building up the county societies and in making their work more practical and useful.

Sec. 2.—The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties.

Sec. 3.—The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Council. He shall receive all bequests and donations to the Association and

shall demand and receive all funds due the Association except accounts due THE JOURNAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the Chairman of the Council. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

The Assistant Treasurer shall give bond at the expense of the Association in such amount as shall be required by the Council unless he is included in the coverage of a blanket or position bond. In case of death, or incapacity of the Treasurer, he shall succeed to all the duties and rights of the Treasurer until a new Treasurer be elected. In the absence of the Treasurer, he shall attend to the duties and rights of the Treasurer during such absence and he shall also perform such duties of the Treasurer as may be delegated and assigned to him by the Treasurer.

Sec. 4.—The Executive Secretary shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Council, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to non-professional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Council, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Council.

Sec. 5.—The necessary expenses of the above officers incurred in the line of duty herein imposed shall be allowed for in the budget, but excepting the Executive Secretary, this shall not include the expenses of attending the Annual Convention.

## CHAPTER VII.—COUNCIL

Section 1.—The Council shall meet as follows: 1. January, April, and July of each year on dates and at places fixed by the Council. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the Chairman, or on petition of three Councilors. It shall hold no meeting that will conflict with any meeting of the House of Delegates. It shall elect a Chairman, and a Clerk, who, in the absence of the Executive Secretary of the Association, shall keep a record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Council shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of Councilors shall begin with the first meeting of the Council following the final session of the House of Delegates at the Annual Session.

Sec. 2.—Each Councilor shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Councilor in the line of the duties herein imposed may be allowed by the Council on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

Sec. 3.—The Council shall, through its officers and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

Sec. 4.—The Council shall, in connection with the House of Deelgates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Sec. 5.—The Council shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse among physicians of

the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

Sec. 6.—The Council shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 7.—The Council shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

Sec. 8.—In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 9.—The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Councilor, and its decision in all such matters shall be final.

Sec. 10.—The Council shall provide for and superintend all publications of the Association, and shall have authority to appoint an editor and such assistants as it deems necessary, and fix the amounts of their salaries. The proceedings of the Council for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Sec. 11.—In the interim between the meetings of this Association the Council shall be the executive body of the Association with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require.

Sec. 12.—The Council shall at its meeting following the close of the House of Delegates elect two members of the Association, at large, or of the Council, who, with the President, the President-elect, the Treasurer, and the Chairman of the Council, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Council they shall not have the power of vote in the Council.

## CHAPTER VIII.—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1.—The work of the Association, the performance of which is not provided for elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Council or of the House of Delegates, or by Special Committees created by the Executive Committee, the Council, or the House of Delegates, shall be performed by the following standing committees and commissions:

The Executive Committee
The Grievance Committee
The Student Loan Committee
The Medical-Legal Review Committee
The Commission on Convention Arrangements
The Commission on Constitution and Bylaws
The Commission on Legislation
The Commission on Public Information
The Commission on Governmental Medical Services
The Commission on Public Health
The Commission on Voluntary Health Agencies
The Commission on Medical Economics and Insurance
The Commission on Inter-Professional Relations
The Commission on Medical Education and Licensure
The Commission on Special Activities
The Commission on the Aged and Aging

The difference between committees and commissions is shown in the provision of these Bylaws pertaining to their work and composition.

Sec. 2.—Unless otherwise provided in these Bylaws, the committees shall be appointed by the President with the chairman of each committee designated by him, and the number constituting each committee shall be as indicated in the section of these Bylaws pertaining to each particular committee.

Sec. 3.—Each commission will consist of fifteen members appointed by the President, with at least one member from each councilor district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise.

Sec. 4.—The President shall have the power, with the approval of the Council, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Sec. 5.—Unless otherwise provided in these Bylaws, no member of either a committee or a

commission shall serve on the same committee or commission more than two consecutive terms, but this shall not prevent him serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Sec. 6.—Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. Then this joint meeting will divide into meetings of the separate commissions, at which time the commissions and committees will organize by the election of chairman, vice-chairman and secretary, unless otherwise provided for in these Bylaws. In these meetings the commissions may provide for such subcommittees within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Sec. 7.—Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Sec. 8.—Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

Sec. 9.—The President and Executive Secretary shall be *ex officio* members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

## CHAPTER IX.—THE EXECUTIVE COMMITTEE

Section 1.—The Executive Committee, constituted as provided in Section 12 of Chapter VII of these Bylaws, shall hold its first meeting immediately following the meeting of the Council held at the close of the last meeting of the House of Delegates in the Annual Convention, and shall organize by electing its chairman. Its secretary shall be the Executive Secretary of the Association. It shall meet with the Executive Secretary on the call of the Chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive Secretary's office. It shall have all jurisdiction with respect to medical defense activities of the Association and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Council, and shall report its actions to the Council.

Sec. 2.—It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

## CHAPTER X.—THE GRIEVANCE COMMITTEE

Section 1.—The Grievance Committee shall be composed of nine physicians, three of whom may be past presidents of the Association, and all of whom shall be appointed by the President. Not more than two physicians shall be appointed from any one councilor district. No member shall hold any elective office in the State Association during tenure on this committee. Of the nine physicians first appointed, three shall serve for a period of one year; three for two years; and three for three years. Thereafter, three shall be appointed each year for a three-year term to fill the vacancies caused by the expiration of terms. Any vacancy occurring in this committee, other than by expiration of term, shall be filled by an interim appointee to serve the balance of the unexpired term. This committee shall organize itself by electing a chairman, a vice-chairman and a secretary.

Sec. 2.—This provision regarding the constitution of the Grievance Committee shall be construed to mean that the present committee of that name is continued in that position with the terms of its members expiring and new members to be appointed on the basis of this provision being operative and effective as of the dates of their respective original appointments; and it is not to be construed as having the effect of creating a new committee, all of whose members are to be appointed upon this amendment being adopted and becoming effective.

Sec. 3.—In addition to the above provided organization and membership of the committee, the Presi-

dent of the Association shall appoint an accredited psychiatrist as a consultant for the committee, whose tenure of office shall be on an annual basis. The appointment of the psychiatrist may be made from any councilor district of the Association, irrespective of the membership of the committee including another member or members from the same councilor district. He shall have the same rights and privileges as other members of the committee except that he shall not have the right to vote.

Sec. 4.—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action cite a member of the Association to the Council of the State Association. It shall, subject to the approval of the Council, draw up a set of rules and regulations governing its procedure and official actions.

## CHAPTER XI.—THE COMMISSION ON CONVENTION ARRANGEMENTS

Section 1.—The Commission on Convention Arrangements, with the advice and assistance of the Executive Secretary, shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Council, and of their respective committees, the scientific and technical exhibits, and in conjunction with the Executive Secretary, shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive Secretary of the Association for publication in THE JOURNAL and in the official programs, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

Sec. 2.—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the annual convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers of the various sections; and it shall, with the approval of the Executive Committee, arrange for scientific exhibits as a part of the Annual Convention.

Sec. 3.—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

## CHAPTER XII.—THE STUDENT LOAN COMMITTEE

Section 1.—The Student Loan Committee shall be constituted as follows:

(a) The President of Indiana State Medical Association
(b) One Councilor of the Association to be appointed by the President
(c) One general practitioner to be appointed by the President
(d) One specialist to be appointed by the President
(e) The Treasurer of Indiana State Medical Association
(f) The Dean of Indiana University School of Medicine
(g) One of the attorneys of Indiana State Medical Association to be appointed by the President

Sec. 2.—This committee shall have authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. The committee shall organize itself at its first meeting following the Annual Convention of the Association, by the election of a chairman and a secretary. The committee shall adopt its own rules and regulations, subject to the approval of the Council. The secretary shall have the duty and responsibility of keeping minutes of all transactions of the committee, and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

## CHAPTER XIII.—THE MEDICAL-LEGAL REVIEW COMMITTEE

Section 1.—The Medical-Legal Review Committee shall consist of three members whose duty it shall be to meet in joint session and work with a similar committee to be appointed by the President of the State Bar Association. This committee of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association.

## CHAPTER XIV.—THE COMMISSION ON CONSTITUTION AND BYLAWS

Section 1.—The Commission on Constitution and Bylaws shall keep in contact with the developments and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

## CHAPTER XV.—THE COMMISSION ON LEGISLATION

Section 1.—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and of the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

## CHAPTER XVI.—THE COMMISSION ON PUBLIC INFORMATION

Section 1.—The Commission on Public Information shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the Commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

## CHAPTER XVII.—THE COMMISSION ON GOVERNMENTAL MEDICAL SERVICES

Section 1.—The Commission on Governmental Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the Government, plans and programs of the Government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

## CHAPTER XVIII.—THE COMMISSION ON PUBLIC HEALTH

Section 1.—The Commission on Public Health shall assemble and study information regarding industrial medical practice, rural health, preventive medicine, placement of physicians, traffic safety, conservation of hearing and vision; and shall bring such information, and the possibility of progress and advancement in such fields, to the attention of the medical profession, with suggestions for improvements as the commission finds such possibilities.

## CHAPTER XIX.—THE COMMISSION ON VOLUNTARY HEALTH AGENCIES

Section 1.—The Commission on Voluntary Health Agencies shall maintain liaison between all voluntary health agencies and the Association; shall study and counsel in regard to planning all educational and other activities of such agencies; and shall keep the Association fully informed at all times regarding present and contemplated programs of these agencies.

## CHAPTER XX.—THE COMMISSION ON MEDICAL ECONOMICS AND INSURANCE

Section 1.—The Commission on Medical Economics and Insurance shall study and improve forms used in medical and hospital insurance; shall continuously be interested in all types of plans for prepayment of medical and hospital expense, and for provision for medical and hospital service through all types of group activity; shall maintain liaison with labor with respect to labor's problems involving medical and hospital care, and Workmen's Compensation problems; and shall seek improved solutions of professional liability or malpractice problems, tax problems in relation to medical practice, and problems involving physician retirement plans.

## CHAPTER XXI.—THE COMMISSION ON INTER-PROFESSIONAL RELATIONS

Section 1.—The Commission on Inter-Professional Relations shall study to find all the best methods of maintaining on the highest and most satisfactory levels physicians' professional relations with hospitals, nurses, dentists, pharmacists, pharmaceutical manufacturers, veterinarians, nursing homes, and all other professional groups with which the practice of medicine comes into contact.

## CHAPTER XXII.—THE COMMISSION ON MEDICAL EDUCATION AND LICENSURE

Section 1.—The Commission on Medical Education and Licensure shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

## CHAPTER XXIII.—THE COMMISSION ON SPECIAL ACTIVITIES

Section 1.—The Commission on Special Activities shall organize and promote support for the American Medical Education Fund, assistance to

physicians, blood banks, and all miscellaneous activities not falling within the area of responsibilities of other commissions or committees.

### CHAPTER XXIV.—THE COMMISSION ON THE AGED AND AGING

Section 1.—The duties of this Commission shall be to study, investigate, and make recommendations to the Association in the areas falling within the question of the aged and aging, including medical care programs, medical care insurance, rehabilitation, and preventive medicine.

### CHAPTER XXV.—REFERENCE COMMITTEES

Section 1.—Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the President in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of five members, at least three of whom shall be members of the House of Delegates. The chairman shall be named by the President from among those who are members of the House of Delegates. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except such matters as properly come before the Council, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

Sec. 2.—The following Reference Committees are hereby constituted to which shall be referred all matters as indicated by the titles of the committees:

(1) Sections and Section Work
(2) Rules and Order of Business
(3) Medical Education and Hospitals
(4) Legislation
(5) Public Relations
(6) Hygiene and Public Health
(7) Amendments to the Constitution and Bylaws
(8) Reports of Officers
(9) Credentials
(10) Insurance
(11) Miscellaneous Business

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the President, be made (a) to as many Reference Committees as are necessary to cover all subjects included therein; or (b) to only one Reference Committee which the President deems has within the scope of its reference the most important part of the matter referred.

No report of any Reference Committee shall be rejected on the ground that it covers something not included in the matters which such Committee was created to consider.

Sec. 3.—The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committees shall have the right to appear and be heard before the respective committees to which such references are made, in regard to their reports.

### CHAPTER XXVI.—COUNTY SOCIETIES

Section 1.—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

Sec. 2.—Charters shall be issued only upon approval of the Council and shall be signed by the President and Executive Secretary of this Association. The Council shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Sec. 3.—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 4.—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine or a degree of Bachelor of Medicine, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be eligible for membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Sec. 5.—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, and its decision shall be final.

Sec. 6.—In hearing appeals the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 7.—When a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed.

Sec. 8.—A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he has his office or has the major part of his practice.

Sec. 9.—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Sec. 10.—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive Secretary of this Association annually on or before February first.

Sec. 11.—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Councilor of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Councilor shall also be sent to the Executive Secretary of the State Association. The State Association shall supply each county secretary a form for these reports.

Sec. 12.—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

The secretary of each component society shall forward the dues for his society, together with the roster of officers and members and list of non-affiliated physicians of the county, to the Executive Secretary of this Association, on or before January 1 of each year and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive Secretary of this Association the dues for such new members.

The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only. Provided, however, that physicians elected to their first membership in this Association during the first nine months of any year shall pay the regular annual dues for that year; and those elected to their first membership after October 1 of any one year shall pay fifty percent of the annual dues as dues for the remainder of that year. Interns and residents shall pay $15.00 a year annual dues during their term of service in the hospital.

In the event the county society remits a member's dues on account of financial hardship, the secretary of the county medical society shall recommend in writing to the councilor of his district the remission of the state association dues of said member of the society, showing why such recommendation should be granted. The councilor in turn shall present the recommendation to the Council, which shall have the power to remit such dues.

Sec. 13.—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 14.—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Sec. 15.—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive Secretary of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive Secretary.

## CHAPTER XXVII.—COUNCILOR DISTRICT MEDICAL SOCIETIES

Section 1.—A Councilor District Medical Society, hereinafter called the District Society, shall be a

society whose members consist of the members of the County Medical Societies in the Counties which constitute the Councilor District, provided such members of County Medical Societies have paid their membership dues in the District Society.

Sec. 2.—The State shall be divided into thirteen (13) Councilor Districts with the boundary lines and numbers of each District to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton and White Counties.

Tenth District—Newton, Jasper, Porter and Lake Counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Sec. 3.—Each District Society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one District Society shall exist within any one Councilor District. The authorized District Society in each Councilor District shall receive a charter from the State Association, and the Secretary of the District Society shall have custody of the charter.

Sec. 4.—Each District Society shall organize by electing a President, a Secretary, and a Treasurer and a Councilor and Alternate Councilor as the current Councilor term and Alternate Councilor term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of Secretary and Treasurer may be held by the same physician. The Councilor shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Sec. 5.—The dues of the District Society, in an amount fixed by the District Society to meet the District Society needs, shall be collected by the Secretaries of the component County Societies and delivered to the Treasurer of the District Society. The Secretary of each District Society shall report to the office of the State Association the names and addresses of the members of his District Society, together with a copy of the minutes of each meeting of the District Society.

Sec. 6.—Each District Society shall meet at least once each year at a time and place to be fixed by the District Society. On or before January 1st of each year each District Society shall notify the headquarters of the State Association of the time and place of the annual District meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Council, the Councilor shall fix the time and place of the District meeting, and notice of such meeting shall be sent to the members of the County Medical Societies in such District.

Sec. 7.—Whenever a District Society is to elect a Councilor and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such District Society not later than the first of March of the year in which the election is to occur.

Sec. 8.—The District Society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the District of the meeting at least thirty (30) days prior to the date thereof.

## CHAPTER XXVIII.—MISCELLANEOUS

Section 1.—The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, when not in conflict with this Constitution and Bylaws.

Sec. 2.—The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

## CHAPTER XXIX.—MEDICAL DEFENSE

Section 1.—One dollar and twenty-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Sec. 2.—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Sec. 3.—This Committee shall have full authority governing all matters pertaining to this Chapter. In order to secure to any physician sued or against whom claim is made a fair and full presentation of his defense, the Committee shall have power to enter into an agreement with such physician to furnish to him funds with which to employ and pay one attorney of his choice and such other expenses as the Committee may approve as necessary to a fair and full presentation of his defense. Provided, always, that the attorney selected by the physician must be of good reputation and standing in his profession and the terms

of employment, including the fees to be paid, must be approved by the Committee in each case in advance of such agreement. Provided, further, that the Executive Committee shall set a limit to the amount which may be so expended in connection with any one claim or case.

Sec. 4.—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the Chairman of the Council.

Sec. 5.—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Sec. 6.—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Sec. 7.—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive Secretary, shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services which are the basis of the suit were rendered.

Sec. 8.—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive Secretary of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the President, Secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Sec. 9.—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Sec. 10.—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Sec. 11.—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Sec. 12.—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Sec. 13.—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Sec. 14.—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

## CHAPTER XXX.—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

## CHAPTER XXXI.—INVESTMENT OF SURPLUS FUNDS

Section 1.—The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Council at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

## CHAPTER XXXII.—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

# Principles of Medical Ethics of the American Medical Association

"PREAMBLE"

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

"Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

"Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

"Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

"Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

"Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

"Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

"Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

"Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

"Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

"Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community."

# COMMERCIAL ANNOUNCEMENTS

DOCTORS office available for immediate possession. Central heating and air conditioning. Located vicinity 10th and Arlington, Indianapolis. Call FL9-5455, Justus Contracting Co.

WANTED: Board eligible certified internist to associate with general surgeon, ophthalmologist and urologist, giving advantage of both solo and group practice. Practice located on Lake Michigan in Wisconsin with population of approx. 50,000 with drawing area of 90,000. Address enquiries to Box No. 316, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

FOR RENT: Six room suite office in professional bldg., Greenwood, Ind. Clinical and x-ray labs and prescription pharmacy in building. Ample paved parking. Terms: very good professional and character references. Rent 15% of monthly gross until figure reaches $290.00 per mth. No retroactive payments. Contact Kenneth I. Sheek, M.D., 360 S. Madison, Greenwood, TU1-3900 for appointment.

WANTED: one or two E.E.N.T. associates to take over best practice in Northern Indiana due to retirement. Eight fully equipped, air conditioned rooms, full surgical equipment. High net income . . . small down payment; will remain to introduce. Write Box No. 317, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

PROFESSIONAL office suite for physician or dentist available in N.E. Indianapolis (outside city limits but 30 minutes from Circle.) Air conditioned. For full details call VA3-4413 or VA3-4528.

GENERAL practice for sale, can include house, and office. Or will sell practice and lease office. Contact L. H. Wiatt, M.D., 108 N. Washington St., Knightstown, Ind., or call Knightstown 5-4405 collect, after 7.00 p.m.

RESIDENCIES—Internships, fully approved in 372-bed hospital with excellent teaching program; vacancies for 12-month rotating internships. Vacancies for 2-year pathology, 2-year general practice, 3-year ob-gyn residencies. Salaries: interns $350 per month, residents $400-$500 per month. Blue Cross family insurance, meals, partial maintenance. Write Director of Medical Education, St. Mary's Hospital, 3700 Washington Ave., Evansville, Indiana 47715.

FOR SALE: Haynes manual hydraulic rectal examinining table; two matched walnut Allison "Monarch" treatment and instrument cabinets. Call Richard B. Moore, M.D. CL5-1606.

WANTED: Physician to associate with three general practitioners. Excellent income, time off for study and recreation. Early partnership available. Write Box No. 318, The Journal, ISMA, 3935 N. Meridian St., Indianapolis.

PROFESSIONAL office for physician in Huntington, Ind. Six rooms, air conditioned, ground floor, easy parking. Doctor's office for past 25 years. Available immediately with modern equipment. Contact Stanley H. Matheny, 45 W. Market St., Huntington or call 356-6811 collect.

GENERAL practitioners 45 or under to assist attending staff and general practice residents in 260-bed general hospital. Annual appointment preferred. $15,000-$17,500 depending on training and experience. Contact Medical Director, San Luis Obispo General Hospital, San Luis Obispo, Calif. Phone: 805-543-1500.

OFFICE space for one or two physicians in downtown Fort Wayne. Office formerly occupied by two general practitioners. Two other doctors in the building. Call or write Dr. George Buckner, 1003 Fulton St., Fort Wayne, Ind.

MEDICAL office building for lease, up to 3,000 sq. ft., 759 N. Shortridge Rd., Indpls., opposite Eastgate Shopping Center. Call now to arrange partitioning and facilities FL 7-6785.

CLINICAL Director of Training and Research, to assume responsibility for active on-going program with 18 residents in a 3-year program fully approved by A.B.P.&N. 2,800-bed hospital accredited by J.C.A.H. Located in beautiful four seasons vacationland. Salary range $18,437 to $22,675 depending on qualifications. Requires minimum of certification and two years' experience. Contact M. Duane Sommerness, M.D., Medical Superintendent, Traverse City State Hospital, Box C. Traverse City, Michigan.

CHIEF of Supervisory Staff needed to help with clinical supervision and teaching in expanding (18 Resident Physicians) fully approved residency training program. Ideal living in active community in the heart of Michigan's Water Winter Wonderland. Newly established position requires board certification and additional experience in clinical supervision. Salary range depending upon qualifications, $17,383 to $21,339 with liberal fringe benefits. Contact Arthur F. Dundon, M.D., Clinical Director, Traverse City State Hospital, Box C, Traverse City, Michigan.

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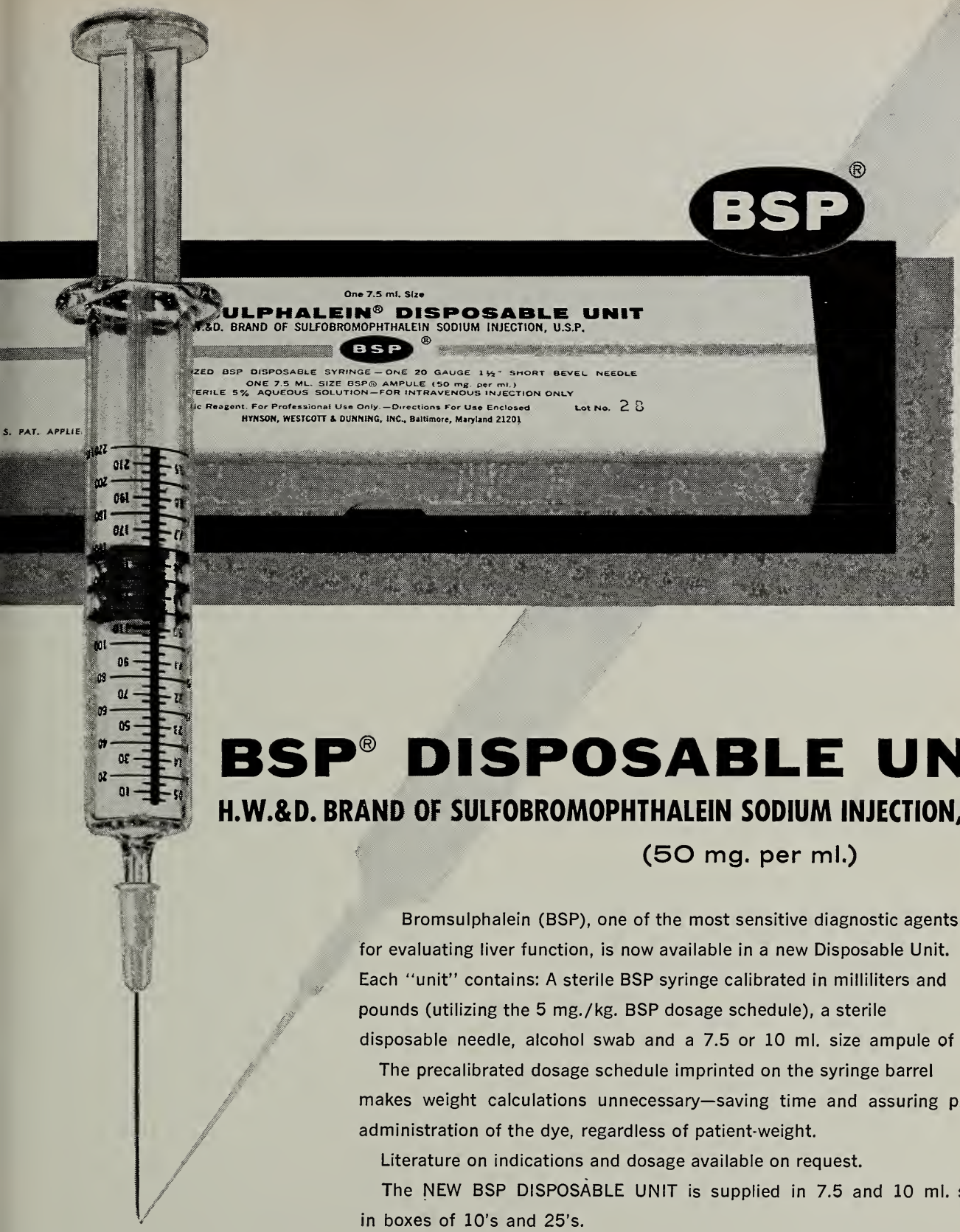
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JULY 1965

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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| 2. | C. Philip Fox, Washington | J. S. Brown, Carlisle | Washington, 1966 |
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| 4. | Merritt O. Alcorn, Madison | Francis W. Hare, Jr., Madison | Madison, 1966 |
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| 6. | William E. Murray, New Castle | Paul M. Inlow, Shelbyville | Shelbyville, 1966 |
| 7. | William C. Stafford, Plainfield | James H. Gosman, Indianapolis | |
| 8. | Lowell Painter, Winchester | Paul W. Sparks, Winchester | Muncie, June 1, 1966 |
| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | May 19, 1966 |
| 10. | Michael Shellhouse, Gary | Edward J. Dierolf, Gary | |
| 11. | Fred C. Poehler, La Fountaine | Max M. Earl, Kokomo | Peru, Sept. 15, 1965 |
| 12. | Warren L. Niccum, Columbia City | Kenneth F. Isenogle, Fort Wayne | May 18, 1966 |
| 13. | Guy B. Ingwell, Knox | Cecil R. Burket, Bremen | South Bend, Sept. 29, 1965 |

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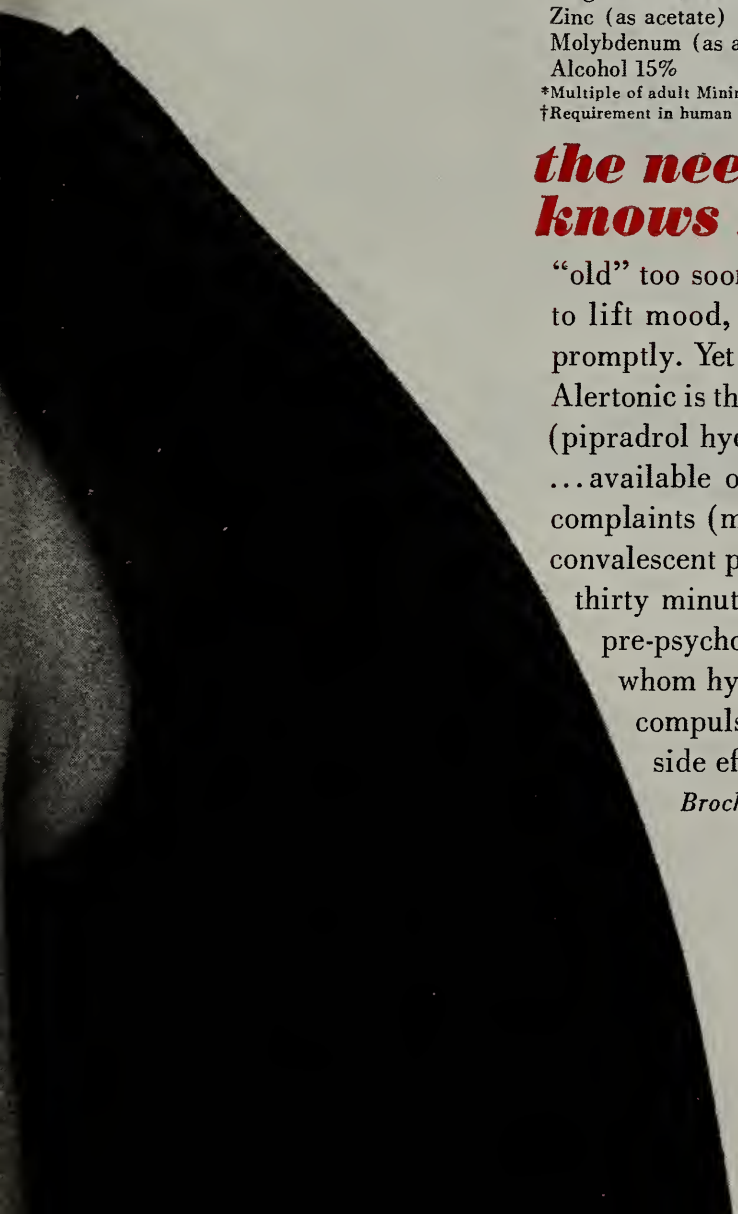
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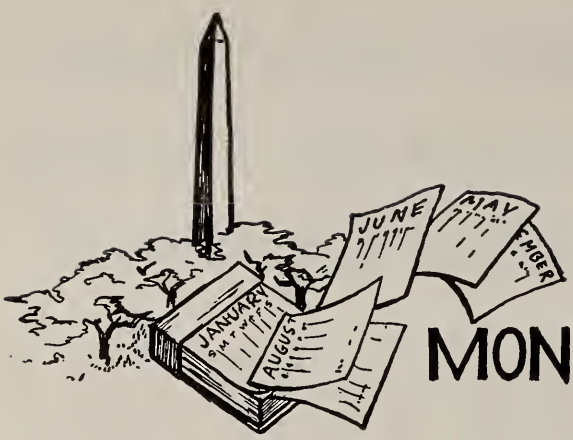
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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D.C.—The American Medical Association warned Congress that passage of the Medicare bill could lead eventually to the troubles encountered in nations that have centralized government medical plans.

"The American system of medicine for generations has been a system of quality medicine, practiced through a voluntary relationship between patients and physicians, with doctors free to make decisions based on the patient's specific needs and nothing else," Dr. Donovan F. Ward, AMA President, told the Senate Finance Committee.

"Yet we have seen the trying problems in other lands and the results engendered by centralized government programs to provide health care for a large segment of the population," Dr. Ward declared. "Long waits, poor equipment and facilities, short, impersonal examinations and lots of record keeping appear to be the major accomplishments of nationalized health systems. Can we hope the American plan will be so different as to negate all these adverse factors?"

"We think not. Forget for a moment the staggering, though unpredictable, cost of the pending program. Ignore the administrative problems that it would create, and the burden it means for wage earners at the low end of the income scale.

"Look only at the intrusion of government in the field of medicine, which cannot be avoided if this measure is adopted. With the quantity of care thus restricted for the sake of controlling costs, the quality must deteriorate. The patient is the ultimate sufferer. But his disillusionment is shared by those who serve him. With the advent of state medicine, professional discontent appears to be the rule rather than the exception. Look again at the experience of the foreign programs.

"This may be our last chance to ask you to write legislation which will meet the nation's needs and at the same time avoid the pitfalls of a government-financed, government-controlled and government-oriented health care system. This may be your last chance to weigh the consequences of taking the first step toward establishment of socialized medicine in the United States," Dr. Ward concluded.

## AMA URGES CONTINUED WAR ON SMALLPOX

Continuing emphasis on vaccination against smallpox in the United States was urged by the AMA. Following announcement that a case of the disease had been discovered in Washington, D.C., the AMA declared that there was no basis for panic or alarm, and said that there was no need for emergency, mass vaccination campaigns.

The AMA said the effectiveness of endeavors of the American Medical Association, local medical societies, physicians, hospital administrations and government health agencies to raise the level of immunity to smallpox through vaccination were challenged with the first case of smallpox reported in this country in 20 years.

Continued



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Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.


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Continued

"Because of the hazard of such importations of smallpox, a disease which can kill or maim, the AMA and others have advocated continuing vaccination programs in this country," the AMA said. "The danger was particularly emphasized over two years ago by Dr. Raymond L. White, director of the Division of Socio-Economic Activities of the AMA. Dr. White pointed out the need for 'defense in depth' through ongoing intensive vaccination programs for those who are apt to contact international travelers, and those who meet or treat the sick, in addition to the general public programs."

## CONNECTICUT CONTRACEPTIVE LAW DECLARED UNCONSTITUTIONAL

The Supreme Court held that Connecticut's 1879 law forbidding use and prescription of contraceptives is unconstitutional.

The majority in the 7-2 opinion said that "a governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedom."

The challenge to the Connecticut law was made by the state's Planned Parenthood League. It stemmed from the conviction of Mrs. Estelle T. Griswold and Lee Buxton, M.D., on charges of violating the law by operating a birth control clinic.

An attempt to challenge the law was made in 1961, but the Supreme Court refused to consider the issue then because no arrests had been made.

"Would we allow the police to search the sacred precincts of marital bedrooms for telltale signs of the use of contraceptives?" the opinion said. "The very idea is repulsive to the notions of privacy surrounding the marriage relationship."

## SUBCOMMITTEE ON AGING MAKES RECOMMENDATIONS

A Senate Aging subcommittee recommended that self-employed persons be given special tax incentives to encourage them to take part in private pension programs. The recommendation was included in a report by the Subcommittee on Employment and Retirement Incomes which held four days of hearings on the subject in March.

The subcommittee endorsed two tax changes that the American Medical Association had urged in a statement to the group earlier this year. One would remove present restrictions in the Smathers-Keogh law that allows tax deferrals on money invested in pension plans by self-employed persons, including physicians. The other would allow physicians who form professional groups to have their business income treated for Federal tax purposes the same as other business corporations.

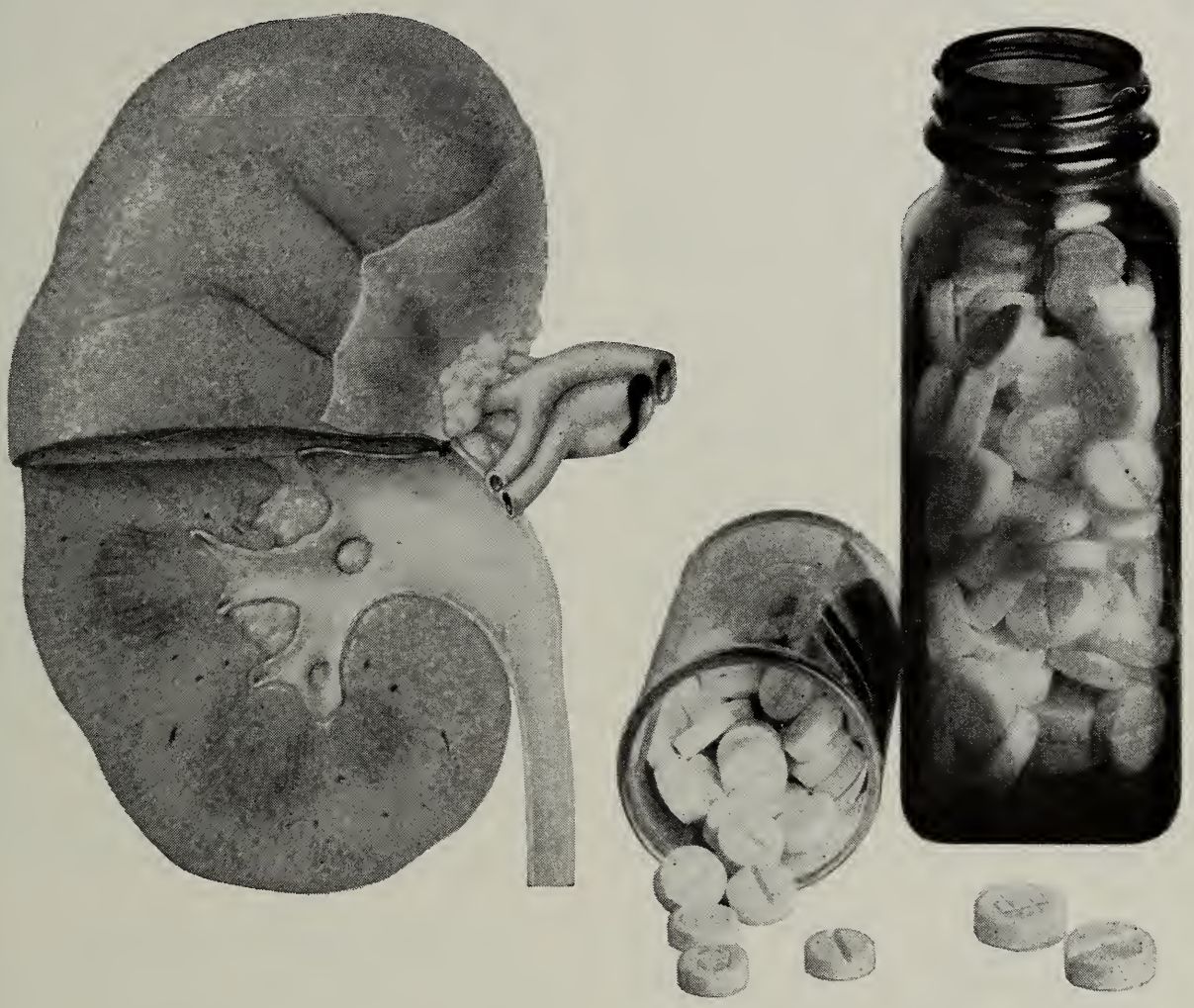
## FDA URGES CORRECT LABELING

The Food and Drug Administration has proposed that foods intended to regulate the intake of fats be accurately labeled to show the amounts and classes of fatty acids, including polyunsaturates, contained in them.

## PMA ESTABLISHES NEW FOUNDATION

The drug industry is establishing a foundation to help promote "scientific and medical research." The foundation being established by the Pharmaceutical Manufacturers Association will plan and initiate research as well as collect and distribute results of the research. It also expects to help finance research projects, the PMA announcement said. The foundation will begin work on a modest scale, "first assembling data on what now is being done in the field by industry, research and educational groups," PMA said. ◄

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The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.
- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## The Medicare Tax

On the matter of tax policy and its impact on economic expansion, the Johnson administration seems to be moving in opposite directions simultaneously.

Remember last year's cut in withholding taxes, advertised as a means to spur the economy? President Johnson won passage of his tax-cut proposals by arguing that more take-home pay would increase consumer spending and give business more incentive for expansion.

Working at cross-purposes with this policy is President Johnson's Medicare bill, which would increase taxes withheld from a wage earner's paycheck and, in the opinion of top administration economists, slow down the economy.

With the Medicare bill safely through the House of Representatives and passage almost certain in the Senate, an official of the President's Council of Economic Advisers had some sobering, if belated things to say about the legislation. Medicare, he predicted, would take money out of circulation at the rate of $5 billion a year starting Jan. 1, 1966.

Benefits, on the other hand, would not begin until July 1966, leaving six months during which the Federal government would be taking more money out of the economy than it puts back in through present Social Security payments. The result, he said, would be less take-home pay, less consumer spending, and a possible cutback in economic expansion. "Pulling that much money out of circulation during the first half of next year could hurt," he concluded.

Interestingly, *The Washington Post* reports that the White House was fully aware of Medicare's possible depressive effect on the economy when it decided to push the bill. The President apparently proceeded full speed ahead on Medicare with full knowledge of its consequences, including the undoing of any benefits from last year's tax cut. Furthermore, he sat on the reports of his economic advisers throughout the House Medicare debate, and the issue of the bill's effect on the economy received almost no attention.

All of this points up the danger of government involvement with the economy. Economic growth requires realistic decisions made free from political considerations. Only private individuals in their roles as producers and consumers—not government—can make decisions of that kind. That is why politicians who promise high rates of economic growth at election time chronically fail to deliver.—*Indianapolis News,* April 26, 1965.

## Tracking Down A Lifesaver

There's a new name among lifesaving "wonder drugs." It is cephalothin, one of a family of antibiotics called cephalosporin. It is the practical result of one of the longest laboratory hunts in the history of antibiotics.

The long trail began in 1945 in the Mediterranean Sea, off the coast of Sardinia. Professor Giuseppe Brotzu of the Cagliari Institute of Hygiene was studying microorganisms where the city's sewers discharge into the sea. He found a fungus which secreted a substance with the power to attack and destroy disease-causing bacteria.

Excited by the discovery, the professor spent three years pursuing it. He succeeded

in growing his fungus in the laboratory and extracting a drug which was tested with some success. Most provocatively, it was effective against the dreaded "staph" infections, which resist penicillin and the sulfas. At the same time it was relatively free from the side effects and adverse reactions sometimes encountered with those drugs. The new substance produced improvement in patients with typhoid and undulant fevers.

Alas, Professor Brotzu's drug was too weak, and too costly to produce. He made a report of his findings, and there the matter seemed at an end. To go farther would require the facilities of a large industrial research laboratory, and there was no such in Italy.

An alert British health officer in Sardinia passed the report to Sir Howard Florey at Oxford University, who had helped to rescue penicillin from the oblivion of a forgotten report. The Oxford laboratories explored it, almost abandoned it because of lack of significant new results. Then after seven years the new antibiotic, dubbed cephalosporin C, was isolated and defined. It was still too weak, but now the work went on with new encouragement. The British National Research and Development Corporation patented the new substance, but efforts to develop it into a practical commercial medicine met failure after failure.

Ultimately the scene shifted to the laboratories of Eli Lilly and Company in Indianapolis. There were more setbacks and more disappointments. But there was also promise and the scale of work was multiplied. At last came the breakthrough, the discovery of a way to produce a cephalosporin derivative—cephalothin—of useful strength and in commercially practical quantities. The trail was 19 years long from the discovery off Sardinia to Lilly production of a marketable drug.

Along the way, the search also produced in other laboratories some new types of penicillin which went into commercial production. Still to be explored are other possible derivatives.

Many individuals and many institutions had a part in the development. There were various key elements—but one without which the others would not have been pos-

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sible. That one key was the patent system. The over-riding reason for lack of a major industrial drug laboratory in Italy is the fact that in Italy there is no patent protection for drug manufacturers. The hunt for cephalothin involved the commitment of large sums of money. The only practical source of such sums, to finance this kind of extended research, is the revenue to be recovered from sale of a patentable product when one is developed, That's why this work was accomplished in countries where that protection is available.

The story of the hunt for cephalothin is a story of perceptiveness, ingenuity, skill, determination and risk-taking—all thriving in the favorable climate of free enterprise economy.—*Indianapolis Star,* May 3, 1965.

## 3 1/2 Months Less Life

Our science writer, John Troan, who keeps track of such facts, reports the average life expectancy in the United States has dropped three and a half months in the last two years.

The National Center for Health Statistics in Washington figures a baby born in 1963 had an average prospect of living to age 69.9 years. Two years earlier the prospect was 70.2 years, an all-time high.

The statisticians blame this on the flu epidemics of 1963 and 1962. In 1963, for instance, there were 55,000 deaths from influenza.

We don't want to quarrel with the experts, but—

If 55,000 deaths from influenza can make a dent in the life-expectancy figure, how about the 43,564 traffic deaths in 1963? This was an increase of 5,500 over 1961. (Last year, the toll was even worse; 47,800 died in traffic "accidents." So far this year, Indiana stands more than 60 deaths ahead of a staggering 1964 toll.)

Flu is pretty hard to deal with when an epidemic strikes. But this is a now-and-then thing. The traffic toll is every day, and it keeps going up. But a genuine jail-type crackdown on speeders and other idiots of the highways could have a real effect on regaining that Biblical average of three score and ten.—*Indianapolis Times,* May 1, 1965. ◄


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*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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# Letters

## to the editor

May 21, 1965

To the Editor:

In a recent issue of *The Journal* you invited comment about *The Journal's* format. There's a backlog of a year or more of scientific papers awaiting publication; it's the responsibility of the editor to design a format that will eliminate the backlog.

The first aim of *The Journal* should be to provide the physicians of this state a means for informing others of medical experiences of general interest. Doubtless this was the original intent of *The Journal* and it should remain so. The reader who critically examines the pages of any recent issue will see at once that this principle is entirely lost.

For example, in the April issue, only 24% of the pages contain original scientific articles. Seventy-six percent of the pages are given to other matters. And not all the material in the scientific section should be there. As an example, there's that unending nonsense from Dr. Arnold Lieberman. I submit that no publisher in Dr. Lieberman's state of New York would print his material. Why should we here in Indiana be subjected to it? It's neither informative nor entertaining; most of it won't meet the standards of acceptable prose.

In each issue, several pages are taken for repetitiously describing the organization of the state association (including a directory of the county societies) yet significant changes occur only annually. An annual or semi-annual description of the societies' organization would be enough.

In every issue there are two or three pages of reprints of newspaper editorials. Anyone interested in what newspapers are printing about medicine can read the newspapers. They are available to all. Why waste valuable space on warmed-over, out-dated material?

There are pages that describe medico-legal problems. All physicians receive various national publications that cover medico-legal matters in greater detail and with greater effectiveness.

Each month pages are allotted to the presidents of the Society and the Auxiliary. Most of this is just trivia. Our presidents don't *always* have something of importance to say to each of us.

Skillfully made book reviews and abstracts are available in our national journals, including the *JAMA*. Yet each month pages of *The Journal* are cluttered with artless reviews and abstracts.

In brief, *The Journal* contains several dull, irrelevant features. They should be eliminated so space is available for a backlog of original scientific articles.

Indiana enjoys a distinguished literary tradition as well as a notable medical tradition. We ought to see in our *Journal* an occasional glimpse of both.

Very sincerely yours,
James E. Keplinger, M.D.
W. Lafayette, Ind.

June 1, 1965

To the Editor:

Mr. Boyer has passed on to me the tearsheet which you sent to him from your May issue. [Page 443, May, 1965.]

It was thoughtful of you to alert us to this public expression of gratitude, and I am passing it on to those at SK&F who were directly involved with replacing the drugs destroyed by the Palm Sunday tornadoes which struck Indiana.

Many thanks again for your kindness.

Sincerely,
G. Frederick Roll,
Director of Public & Industry Affairs
Smith Kline & French Laboratories

June 11, 1965

To the Editor:

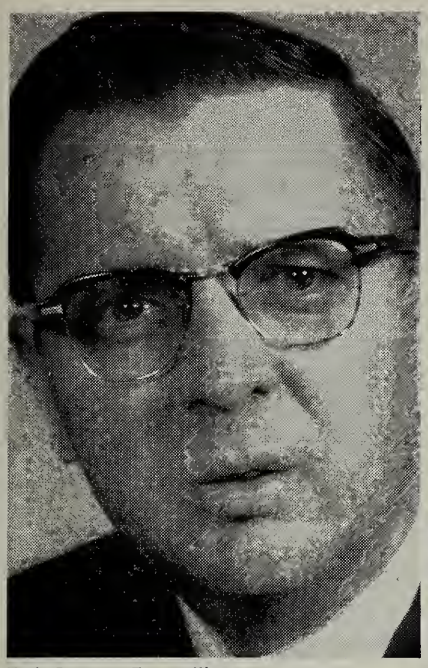
Thank you for sending the tearsheet from *The Journal of The Indiana State Medical Association.* Please thank those responsible for the favorable comment concerning Eli Lilly and Company. We appreciate it very much.

Sincerely,
Eugene N. Beesley
President
Eli Lilly and Company

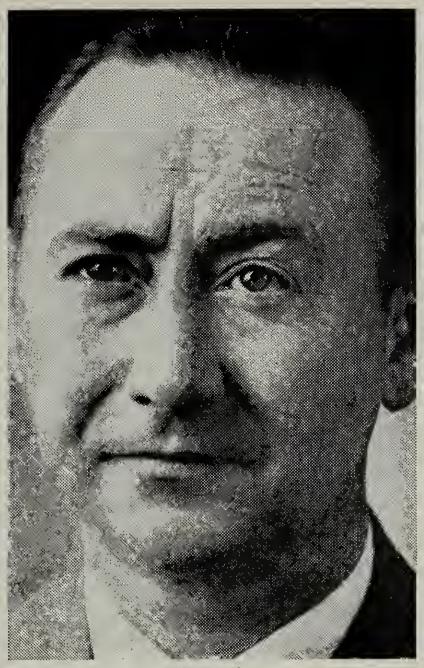
May 20, 1965

To the Editor:

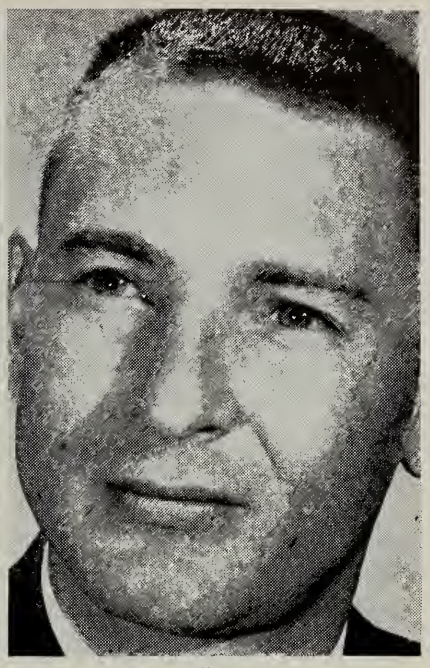
On April 7, at noon, 30 physicians of a newly organized Physicians for Automotive Safety made a "dignified protest" before



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Continued

the 1964 International Automobile Show at the New York Coliseum. Fourteen specific objections to current automobile design were indicated on the placards which the physicians carried. Since the protest, the response from the public and our fellow physicians reflects sentiment that our action was long overdue. Despite past intensive programs directed at control of the environment (the highway) and the host (man), little attention has been directed towards preventive countermeasures for the specific agent (the automobile). Defective automobile design is responsible for much of the epidemic injury, disfigurements and disabilities.

All the previous resolutions of the American Medical Association and the American College of Surgeons asking that the industry make a safer car have been almost completely ignored. There will be no conflict with the regular medical organization activities on automotive safety, and the Physicians for Automotive Safety will cooperate to reinforce the mutual objective.

The Physicians for Automotive Safety, as a smaller and more flexible organization, will direct programs specifically to effecting occupant protection in motor vehicles. Physicians for Automotive Safety represents the first attempt at organization of the practicing medical profession to cope with a known mechanical epidemiologic agent. The nature of the present epidemic clearly justifies this approach.

Membership inquiries and suggestions for future action should be directed to Dr. Arnold Constad, Secretary-Treasurer, 527 Morris Ave., Springfield, New Jersey. Basic membership fee is $5, contributing membership $15, sustaining membership $25 per year. Hopefully, physicians from every section of the country will join to give meaningful influence for this new medical group.

Sincerely yours,
Seymour Charles, M.D.
President
Newark, New Jersey

Leo Mayer, M.D.
Vice-President
New York, New York

---

May 3, 1965

Dr. Albert Donato, President
Marion County Medical Society
2902 N. Meridian St.
Indianapolis, Indiana 46208

Dear Dr. Donato:

On behalf of myself and the WFBM Stations, I should like to thank you and your organization and the American Medical Association for the very generous cash award presented to us on April 15th. I'm looking forward to accepting the plaque from the AMA House of Delegates on June 21st. We are indeed highly honored by this singular recognition of an effort in the area of family planning.

Award winners are supposed to feign humility and the like. In my case, however, it is very humbling. The award was for a specific radio program, "New G.Y.N. Clinic Opens" (at General Hospital). It capped a nine-month drive to get public policies changed in the Marion County Department of Public Welfare and the Public Health Clinics, operated by the Health and Hospital Corporation. If awards are to be passed out, they rightfully should go to the people who were joined in the struggle to change men's minds and to the people who changed their minds, for that matter. But special credit obviously goes to the Executive Board of the Marion County Medical Society as represented frequently in the birth control debate by Dr. Irving Rosenbaum and his colleagues. It takes courage to stand up and demand "reverent" public policies be changed in the face of controversy and deep-seated prejudices.

Among those who assisted Dr. Rosenbaum were Dr. Charles Gillespie, Chief of Obstetrics at General Hospital, and a host of residents and physicians who shared the belief that poverty should not be a bar to the availability of modern science and the benefits of new knowledge. Doctors Gillespie and Rosenbaum (and the Medical Society) successfully enlisted the aid and understanding of Dr. Arvine Popplewell,

Superintendent at General, and others in setting up the clinic. It has proven itself in the 11 months it's been in operation. This success is a tribute to the forward-thinking of the Board members of the Health and Hospital Corporation.

The continued cooperation of Dr. Henry Nester, Marion County Health Officer, will widen the scope of such services in the future. His understanding of a delicate problem and implementation of a Board policy has enriched the lives of many unfortunate women already. The unsung Public Health Nurses' cooperation is vital to the continued success of this program.

Of course, the guidance and manpower supplied by Mrs. Gordon McCalment, Executive Director of the Planned Parenthood Association of Indianapolis, has been vital to the clinic's success. She and Mrs. Florence W. Binford, President of PPA, have been in the forefront of what has been a laboriously-long struggle. They have never flagged in their dedication. The PPA has supplied nurses and materials to assist in the clinic's operation. Consequently, the clinic stands as moot evidence that private and governmental agencies can cooperate effectively in achieving a worthwhile goal.

In retrospect, I marvel at the skill and diplomacy which was used in achieving both the result, as witnessed by the clinic's success, and the public understanding necessary to continued operation. In other communities, there have been "bloody" controversies over this very subject. In Indianapolis, however, the enlightenment represented by the Medical Society, the PPA, the Health and Hospital Corporation, the Marion County Department of Public Welfare, the Archdiocese of Indianapolis and certain individuals already named has produced an harmonious success story unrivaled in the Midwest.

As you know, I'm sure, we in Indiana have earned the label of "conservative" but very often we surprise ourselves by taking sweeping actions which reverse a long trend in the opposite direction. Such forward progress is the result of a gathering-in of all the evidence, analyzing it calmly, reaching a logical conclusion and then implementing a just decision. Such is the case here. The Medical Society can be rightfully proud of its hand in this matter. It's the kind of image-building action which could be encouraged in other areas.

I was delighted on April 15th to hear Dr. Joseph Black, President of the State Medical Association, say that the model project begun here by the Marion County Medical Society could—and very likely would—be duplicated in other metropolitan areas of the state. As I recall, he said, "We look to Indianapolis for leadership . . . because with the Medical Center here and all, it is the seat of medical learning in Indiana. I think this will be accepted generally throughout the state."

I recently accepted membership on the Board of Directors of the newly-formed Indiana Family Planning Association, Inc. It is the purpose of this group to set up more clinics in Marion County and, provided Federal funds are available under the program being administered by the Office of Economic Opportunity, other clinics in such communities as Lafayette, Muncie, Bloomington, Gary and Hammond. Your continued support of the principle of properly-administered family planning clinics is solicited.

Again allow me to thank you for this highly-prized honor.

Sincerely,
Gene A. Slaymaker
Radio News Editor
The WFBM Stations

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 58 — July 1965 — Number 7

# Three Cases of Leptospirosis Contracted from Hogs

MARGARET A. BASSETT, M.D.
Thorntown

LEPTOSPIRA infection was first reported in man in the United States in 1951.[1] Since this first recognition of a human infection, a few additional cases have appeared in the literature.[3-5] The disease is transmitted easily enough to man from livestock to made it one of the possible diagnoses in febrile conditions affecting those who work with hogs and cattle.

There are 40 strains of Leptospira, all of which may be differentiated by agglutination tests. The Leptospira pomona is the most important strain from a clinical viewpoint.

Leptospira pomona infection in swine causes abortion, debility, inability to stand, rigidity and spasm, and gastrointestinal disturbances with anorexia. It seldom causes death. After the acute infection, swine may have leptospiruria for six months.[3]

In cattle, it produces hemoglobinuria and hemoglobinemia, but cows usually recover. Mortality is high in calves, however. The urine of the cattle may remain infectious for three months.[3] Leptospira infections in man are contracted by handling infected animals, animal products or excreta. Portals of entry are the gastrointestinal tract, respiratory tract or through a break in the skin.[4]

Leptospirosis may cause (1) an influenzal like syndrome, (2) aseptic meningitis, (3) hepatitis, (4) nephritis, (5) hemorrhage and vascular collapse.[5]

There are often three phases: (1) a septicemic acute infectious stage for four to seven days, (2) a brief remission and (3) an immune phase with reappearance of fever. Uveitis, meningitis or hepatitis may appear in the third stage. Icterus appears in five to ten percent with a mortality of 25%. Uveitis may appear as late as four to eight months after the original infection.[2-4]

### Laboratory Data

The spinal fluid cell count is usually 50-300 with lymphocytes predominant after the 12th day — protein is rarely over 140.

Spirochetemia is present the first week. Laboratory animals may be inoculated with blood or urine in order to isolate the organism. The Leptospira are difficult to demonstrate.

The white blood count is too variable to be of diagnostic value.

Blood serologic tests for leptospirosis become positive in the second week. Recovery is accompanied by a solid immunity and specific lysin is present in the blood in detectable amounts for several years.

To date antibiotics — penicillin or tetracycline — are of questionable value.

A small industry producing hog cholera serum has operated in this community since 1915. No breeding stock is kept at the plant. Pigs are bought from farmers when about six months old, are kept in barns at the plant and hyperimmunized with hog cholera serum. They are bled on the tenth or eleventh day and every seven days there-

after for three weeks. Then they are butchered and sold.

Approximately 14 men are employed there. All of the men function in all parts of the above procedure.

The late Dr. Clancy Bassett, who practiced here from 1907 to 1960, had treated several employees of the plant in the past for febrile illnesses characterized by prolonged high fever and aching. These illnesses were more severe and lasted longer than cases of influenza, which they superficially resembled. At different times through the years, blood was drawn for Widal tests and for hog cholera testing but always was reported as negative.

### Case Reports

*Case #1* — A white male, age 53, had a sudden onset of fever and general aching on 10-12-62. Examination was essentially negative. A tentative diagnosis of viral infection was made and he was instructed to go home, remain in bed and take ASA compound. He returned to work on 10-19-62 but was still not feeling well. He worked for three days, then his fever recurred.

He returned to the office for reexamination on 10-30-62 with a temperature of 99.4 F (37.4 C) and complained of soreness in the shoulders, hips and knees. He stated that he had probably had a fever ever since his first visit but had not taken his temperature. He also stated that during his illness he had lost weight and complained of thirst although he had a good urinary output. He had a slight cough and his weight loss was considerable (usual weight 165-170, present weight 143 lbs.) Physical examination was again essentially negative; urinanalysis was also negative. He was admitted to the hospital for further observation.

His temperature on the evening of admission was 101.0 F (38.3 C), the following evening 99.4 F (37.4 C) and thereafter normal. Physical examination once again was negative. His laboratory work was reported as follows: Urinanalysis — normal except for rare granular casts. Hemoglobin — 13.8 gms.; red blood count — 4,800,000; white blood count — 5,450; segs. — 50%; bands — 7%; lymphs. — 38%; monos. — 5%; blood sugar — 110 mgms.; NPN — 16.2 mg. Agglutinations: typhoid H — 1:180, paratyphoid A — 1:40 and all others negative. Antistreptolysin — 129 Todd units, Mazzini — neg. A blood count made five days after the first count was reported as follows: hemoglobin — 12.0 gms.; red blood count — 3,880,000; white blood count — 5,950; segs. — 53%; eosinophils — 5%; lymphs. — 38%; monos. — 4%. Chest x-ray was negative. He was discharged as improved and placed on ASA for soreness in joints on 11-5-62. After being discharged from the hospital, tetracycline was prescribed for bronchitis.

After dismissal the leptospirosis serologic test drawn while the patient was in the hospital was reported as follows: L. canicola: reactive 1:1040; L. icterohaemorrhagiae: reactive 1:256; L. grippotyphosa: reactive 1:256; L. pyrogenes: reactive 1:256; L.. autumnalis: reactive 1:128; **L. pomona: reactive 1:4096;** L. sejroe; reactive 1:256; L. australis: reactive 1:512; L. mini (LT117): reactive 1:256. Repeat agglutinations on 11-21-62 were as follows: L. canicola: 1:128; L. icterohaemorrhagiae: 1:512; L. grippotyphosa: 1:128; L. pyrogenes: 1:64; L. autumnalis: 1:32; **L. pomona: 1:4096;** L. sejroe: 1:64; L. australis 1:64; L. mini: 1:64. Further agglutinations on 12-26-62 revealed: L. canicola: 1:32; L. icterohaemorrhagiae: 1:64; L. grippotyphosa: 1:32; L. pyrogenes: 1:64; L. autumnalis: 1:32; **L. pomona: 1:2048;** L. sejroe: 1:16; L. australis: 1:32 and L. mini: 1:32.

He continued to improve at home, gained five pounds and returned to work on 11-19-62.

*Case #2* — A white male, age 33, became ill on 8-1-63 with generalized aching and fever. His temperature was 99.0 F (37.2 C). Physical examination was negative. On 8-2-63, he continued to have fever and chilling and also complained of nausea and vomiting. His urinanalysis was negative except for two plus albumin.

On 8-3-63, his temperature was 103.4 F (39.7 C), urinanalysis was reported with two plus albumin and a few hyaline and granular casts. He was admitted to the hospital. On 8-5-63, his temperature was 99.0 F (37.2C), he complained of severe

headache, had slight meningismus and was still vomiting. He was started on tetracycline 250 mg., every six hours with a diagnosis of possible leptospiral infection. He felt improved in the evening, and continued to improve thereafter, becoming afebrile on 8-7-63. He was never definitely jaundiced. His liver was never palpable.

Chest x-ray on 8-3-63 was negative. Laboratory tests on 8-4-63 were as follows: Hemoglobin — 14.2 gms.; red blood count — 4,660,000; — white blood count — 6,300; hematocrit reading — 39%; segs. — 68%; bands — 9%; eosinophils — 2%; lymphs — 18%; monos. — 3%. Agglutinations; typhoid 0 — neg.; typhoid H — neg.; paratyphoid A & B — neg.; proteus OX19 — 1:40; Brucella abortus — neg. Urinanalysis: straw, cloudy, acid, sp. gr.1.010; alb. — 2 plus; sugar — neg.; white blood cells — 10-15/hpf.; red blood cells — 0-4/hpf. epith. cells — 5-10/hpf.; granular casts — 0-5/hpf. Blood culture on 8-5-63: No growth, stains — neg. Subcultured on 8-7-63 — Thioglycolate, Fletchers culture medium — no growth. Urinanalysis: alb. — trace; red blood cells — many; epith. cells — 10-15/hpf.; hyaline and granular casts — occasional. Total bilirubin — — 0.5; van den Bergh (direct) — 1.05; van den Bergh (indirect) — 0.45; icterus index — 9.0; blood in Fletchers culture medium for Leptospira — no growth; stains — neg. Cephalin flocculation (24 hrs.) — 3 plus; cephalin flocculation (48 hrs.) — 4 plus. L. pomona: Reactive 1:128 on 8-12-63.

He was discharged in an asymptomatic state except for weakness on 8-9-63. He was to continue tetracycline and bed rest at home.

Outpatient cephalin flocculation tests and agglutinations for leptospirosis were as follows: (8-14-63) icterus index — 9.0; cephalin flocculation (24 hrs.) — 4 plus; cephalin flocculation (48 hrs.) — 4 plus. On 9-3-63, L. pomona was: 1:256 (or more). Icterus index on 9-6-63 — 7.5; cephalin flocculation — 4 plus. L. autumnalis, and L. sejroe on 9-11-63: reactive; L. pomona: 1:256. Icterus index on 9-20-63 — 6.5; cephalin flocculation (24 hrs.) — 3 plus; cephalin flocculation (48 hrs.) — 4 plus; cephalin flocculation (24 hrs.) on 10-11-63: — 1 plus, cephalin flocculation (48 hrs.) — 2 plus. L. pomona on 11-18-63: 1:64. He continued to improve on a modified rest program at home and returned to work on 9-26-63.

*Case #3* — A 41-year-old white male was first seen when he collapsed at work. He stated that he had had aching and nausea for two days. His temperature was 101.4 F (38.6 C), and physical examination was negative. Blood was drawn for base line leptospirosis titer and he was sent home, on ASA. On 8-31-63, his temperature was 103.8 F (39.9 C) and he was started on tetracycline with a tentative diagnosis of leptospirosis. On 9-2-63 his temperature was 100.0 F (37.8 C) and he complained of a severe headache. On 9-3-63 he was afebrile and had no complaints other than weakness.

On 9-9-63 he reported that he felt well but that all his hogs were sick and that the veterinarian who had performed a postmortem examination on one said that it had lesions typical of leptospirosis. When I contacted the veterinarian to ask for blood samples from the hogs to send to the laboratory, he reported that the hogs had all died. The patient's laboratory tests were as follows: Serologic test for leptospirosis on 9-3-63 — non-reactive. Icterus index on 9-4-63 — 4.5; cephalin flocculation (24 hrs.) — 2 plus; cephalin flocculation (48 hrs.) — 3 plus. L. autumnalis on 9-6-63: reactive; L. pomona: 1:64; L. sejroe: reactive. Cephalin flocculation (24 hrs.) on 9-10-63 was 2 plus; cephalin flocculation (48 hrs.) — 4 plus. L. pomona on 9-11-63 was 1:128. Cephalin flocculation (24 hrs.) on 9-17-63 was 3 plus; cephalin flocculation (48 hrs.) — 4 plus. L. pomona on 10-10-63 was 1:64. Cephalin flocculation (24 hrs.) on 10-12-63 was 3 plus; cephalin flocculation (48 hrs.) — 4 plus. He returned to work on 9-24-63, asymptomatic.

### Comment

The triphasic course of leptospirosis was demonstrated only in Case #1. Here the serologic titer was much higher than in the other two cases. This might well be due to tetracycline being used late in the second phase while the other two patients received it early in their illness.



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It is also pertinent to note that the headache and vomiting continued, and at least in case #2, became worse for a day or two after the temperature was normal.

Case #2 had urinary findings of nephritis and both cases #2 and #3 showed hepatic involvement.

Blood was drawn on 1-17-64 from 14 employees of the serum plant for agglutinations against Leptospira and also on several retired employees to see if any of them had had subclinical infections. All four of the retired employees and nine of the employees were non-reactive. Six employees were reactive, including the secretary with no history of illness. Two of them had had febrile illnesses during the summer of 1963; the other three were included in the cases reported. The reactions were:

1. L. pomona: 1:64
2. L. pomona: 1:128
3. L. pomona: 1:16
4. L. pomona: 1:128
5. L. icterohaemorrhagiae 1:64
6. L. icterohaemorrhagiae 1:16 (the secretary)

It may well be that #4 and #5 also had had acute leptospiral infections.


**Summary**

Three cases of leptospirosis occurring in employees of a hog cholera serum plant are reported.

They were all treated with tetracycline, the first late in the course of his illness and the last two early in the illness. The two treated early did not have a secondary rise in temperature but did have a long period of convalescence.

More cases should be observed to determine the efficacy of tetracycline in the treatment of leptospirosis.


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218 E. Main St.
Thorntown, Ind.

# Intralesional and Intramuscular Injection of a New Corticosteroid Mixture in 70 Dermatologic Patients

M. MURRAY NIERMAN, M.D.
Calumet City, Ill.

IN THE TREATMENT of skin disease with corticosteroids, the onset and duration of corticosteroid activity can be controlled through the rate of absorption of the steroid. This is a preliminary report on the use of a corticosteroid (betamethasone) mixture formulated for both rapid and gradual absorption following injection. The mixture contains 3.0 mg. per cc. of betamethasone disodium phosphate, an ester that is quite soluble in aqueous solution; and 3.0 mg. per cc. of betamethasone acetate, an ester that is only slightly soluble in aqueous solution.

The parent compound of both esters, betamethasone alcohol, is a synthetic derivative of prednisolone that exerts glucocorticoid activity which is greater than that of prednisolone[1,2] and more prolonged.[3] Results of treatment of 494 patients with oral betamethasone alcohol were reported previously by the author,[4] and provided the basis for comparison of treatment with the injectable betamethasone mixture.

Seventy patients with steroid-responsive dermatologic disorders (Table 1) were selected from private practice in an industrial community where occupational dermatoses frequently occur. The patients, 37 females and 33 males, ranged in age from three to 73 years (Table 2). Approximately one-third of these patients had recurrences of conditions which had previously responded to treatment with corticosteroids. Choice of systemic (intramuscular) or intralesional treatment with the betamethasone mixture* was made according to diagnosis.

In contact dermatitis, for example, intramuscular injection for systemic effect was given, whereas in disorders such as psoriasis, keloids and alopecia areata, where concentrated local effect was desired, intralesional injections were given. Up to three intralesional injections of approximately 0.3 cc. were given, 3 cm. or more apart. No more than three such injections were made per visit however, so that the maximum dose given at any time was 1 cc. (6 mg.) of betamethasone. The total amount of betamethasone received by the patients during the course of treatment did not exceed 6.0 cc. (36 mg.) except for patients with alopecia, who received up to 9.0 cc. (54 mg.) over several months.

In 38 cases of severe dermatitis, treatment was given initially at intervals of one to three days; in the other cases, initial treatment was at intervals of four to seven days.

In all cases, the intervals between subsequent injections usually increased as the disease abated; the longest interval between injections was eight weeks.

## Results

Results of treatment with the betamethasone mixture in 70 patients are given in Table 1. Good to excellent anti-inflammatory and antipruritic activity was obtained in all but one of the patients who continued therapy long enough to obtain benefit. The single treatment failure was a case of pseudopelade in a 41-year-old male whose cicatricial lesions and resultant hair loss had become progressively worse during the previous year despite treatment with chloroquine, vitamins and topical agents. Because hair grew at the edges but not away from the site of injection, this case was considered a treatment failure.

Results were recorded as incomplete in two cases: in one, the patient had alopecia areata and accepted only three treatments;

* Celestone® Soluspan™, supplied for this study by Roger W. Cooper, M.D., Schering Corporation, Bloomfield, New Jersey.

RESULTS OBTAINED WITH INJECTIONS OF A BETAMETHASONE MIXTURE IN 70 PATIENTS WITH STEROID-RESPONSIVE DERMATOLOGIC DISORDERS

| Diagnosis | Excellent | Good | Poor | Results Incomplete | Total |
|---|---|---|---|---|---|
| Contact dermatitis | 14 | 7 | | | 21 |
| Eczema | 7 | 5 | | | 12 |
| Alopecia | 3 | 5 | 1 | 1 | 10 |
| Dermatitis medicamentosa | 4 | 1 | | | 5 |
| Urticaria | 3 | 2 | | | 5 |
| Psoriasis | 1 | 2 | | | 3 |
| Keloids | | 2 | | | 2 |
| Lupus erythematosus, discoid | | 1 | | | 1 |
| Lupus erythematosus, disseminated | 1 | | | | 1 |
| Scleroderma | 1 | | | | 1 |
| Infectious dermatitis | | 1 | | | 1 |
| Lichen planus | | 1 | | | 1 |
| Lichen chronica simplex | 1 | | | | 1 |
| Seborrhea with hair loss | | | | 1 | 1 |
| Purpuric dermatitis, acute | 1 | | | | 1 |
| Dermatitis herpetiformis | | 1 | | | 1 |
| Exfoliative dermatitis | 1 | | | | 1 |
| Pruritis ani, lichenoid | 1 | | | | 1 |
| Kaposi's varicelliform eruptions | | 1 | | | 1 |
| Total | 38 | 29 | 1 | 2 | 70 |

TABLE 1

there was no evidence of hair regrowth on the 22nd day after the first treatment. In the other case, the patient had severe seborrhea with loss of hair on the front and crown of the scalp. This patient, who also accepted only three treatments, had no hair regrowth after five weeks. Results in these two cases were classified as *incomplete* rather than treatment *failures* because hair regrowth is seldom apparent before six or eight weeks of therapy.

No steroid side effects were observed in the patients. It was our impression, however, that injection of this complex was painful for some patients, although the addition of a local anesthetic to the mixture was not required in any case.

The effect sought, and upon which the efficacy of the mixture was judged, was the relief of inflammatory and allergic manifestations of the disorder, irrespective of etiology. Criteria for its evaluation are reflected in the following case histories:

AGE RANGE OF PATIENTS

| Age | Patients |
|---|---|
| 3 - 12 | 2 |
| 13 - 20 | 9 |
| 21 - 30 | 12 |
| 31 - 40 | 14 |
| 41 - 50 | 16 |
| 51 - 60 | 11 |
| 61 - 73 | 6 |
| | Total 70 |

TABLE 2

### Case Histories

*Case 1.* A 49-year-old man had contact dermatitis of the face of industrial origin (dermatergosis) characterized by severe, weeping eczema. Three months of treatment with topical agents had produced no significant improvement. He was given 1 cc. (6 mg.) of the betamethasone mixture intramuscularly at the first treatment, 1 cc. (6 mg.) the next day, then 0.5 cc. (3 mg.) on the third day. Treatment was then deferred until the 10th day, when another 0.5 cc. (3 mg.) was injected. Exudation diminished the first day after injection; inflammation, cracking, and scaling were noticeably reduced on the second day. The lesions became less erythematous; new skin grew in from the margins. Result: *excellent.*

*Case 2.* A 14-year-old girl had severe bullous dermatitis medicamentosa on most of her body. She had undergone radiologic examination of the kidneys and treatment

with sulfonamides, and it is not clear whether the agent provoking the dermatitis was the radio-opaque dye or a sulfonamide. One cc. (6 mg.) of the betamethasone mixture was injected initially and again two, four, nine, 13 and 27 days later. The lesions began to subside in 24 hours and disappeared before the final treatment. The betamethasone mixture suppressed the reaction promptly, avoiding possible recrudescence. Result: *good.*

*Case 3.* An 18-year-old boy had patchy loss of scalp hair which had begun some years earlier. The disease had shown some remission, but was becoming progressively worse despite treatment with topical corticosteroids. The hair-loss pattern was not hereditary. The betamethasone mixture was injected intradermally (1.0 cc., divided doses, 3 cm. apart) at intervals of one or two weeks for a total of nine treatments in 11 weeks. Result: *good.*

*Case 4.* A 65-year-old man, who had been treated with antimalarial agents for a patch of discoid lupus erythematosus on the face and neck of five years' duration, was treated with one cc. (6 mg.) of the betamethasone mixture injected into the lesion. With no further treatment, the lesion faded to a patch of brown skin, a *good* result.

## Comment

The betamethasone mixture is readily evaluated because its pharmaceutical design is based on rate of absorption and activity of betamethasone esters. Clinically, it produces rapid and sustained corticosteroid effects, probably because the soluble ester — betamethasone disodium phosphate — is absorbed rapidly by the tissues, whereas the slightly soluble ester — betamethasone acetate — is absorbed gradually from the depot produced on injection. Treatment of short-term disorders is facilitated by the continued corticosteroid activity of the mixture.

Intralesional injection in the regimen described permits intensive local therapy not obtainable with other dosage forms of betamethasone. Moreover, partial suppression of some lesions distant from the site of injection may be observed, probably because part of the soluble betamethasone disodium phosphate is absorbed systemically.

Maximum dosage of one cc. per week, either intradermally or intramuscularly, avoids the side effects of systemic steroids occasionally seen in short-term treatment with higher doses. Careful injection with a fine-bore needle deposits the steroid intradermally, avoiding possible necrosis of the subcutaneous fat and dimpling of the skin.

## Summary

A new steroid preparation, a mixture of betamethasone esters of differing solubility, was administered by intramuscular or intralesional injection to 70 patients with steroid-responsive dermatologic disorders. Rapid and sustained anti-inflammatory and antipruritic activity was obtained in 67 of these 70 patients; there was one treatment failure and two cases in which therapy was not completed. With maximum dosage of one cc. (6 mg.) a week, intramuscularly, or in divided doses intradermally, steroid side effects were not observed.

The four cases described above have remained free of recurrence as per last communication.

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# Round The Red Lamp*

## With Apologies to Dr. Conan Doyle

JOHN H. OLIVER, M.D.†



**Read before the Indianapolis Literary Club on April 21, 1924; re-read before the club on January 14, 1946 by William Niles Wishard Jr., M.D., and before the Indianapolis Medical Society on February 5, 1946.**

EVER SINCE the beginning of medical practice in England, dating back to and having its origin, no doubt, during the era of the barber surgeons, a red lamp has been the insignia which has lured the ailing public into the toils of the practitioner of medicine. I have heard it intimated at times by malevolent individuals only, that doctors' offices should be marked in a similar manner in this country, the sinister meaning of which has always been resented by the profession.

Some years ago, Dr. Conan Doyle, then an ordinary student and practitioner of medicine, before premature senile conditions and a love for ectoplastic art had affected his brain and led him into the realms of the unknowable, presented to the reading public a series of personal reminiscences and sketches, all of a professional or semi-professional nature, under the caption, "ROUND THE RED LAMP." In it he related experiences and happenings of his student and early professional life and made of it a very readable volume. It has often occurred to me that I might sometime possibly interest the club in a similar collection of happenings from my own stores and weave them into a bit of fustian in which there was nothing to discuss, that might be soothing to tired minds as they rested from the consideration of more consequential things.

It was not until the reading of this book called my attention to the fact that I discovered that the hallway leading to my office had been lighted by a lamp of similar color for many years. In the early days, before many victims had been attracted by its seductive rubicund rays, an evening's contemplation was unexpectedly interrupted by the hurried advent of an excited messenger. "Come with me, Doctor, right away, please;

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† Deceased.

there is a lady bleeding to death."

To such a summons as this, no true physician ever hesitates to respond. It was old Guy de Chauliac, I believe, who in the early days of medicine wisely remarked that it took a brave man to look into the mouths of open blood vessels; and this sage expression came from the depths of personal experience which has been voiced by many a man and brother ever since.

### Help for Hemorrhea

My anxious companion hurried me to the second floor of a nearby block and ushered me unceremoniously into a sumptuously-furnished apartment where I found the cause of the trouble reclining on a blood-bespattered bed surrounded by a number of excited females.

The patient was the coolest individual in the room, perfectly calm and seemingly unconcerned; she appeared to be somewhere about thirty years of age, with fine eyes, intelligent face, and possessed of that indefinable something that denotes good breeding. She gave me as much of her history as I would allow between gulps of bright frothy blood, in a scarcely audible voice.

This attack had come on suddenly a short time before. She had had a similar one several years earlier. She had lost the outer third of her left clavicle when a young girl, resultant from a compound fracture caused by a fall from her horse while fox hunting at her home in Virginia. A sister had died from hemorrhage of the lungs before her party gown could be removed, and her brother had gone the same way.

Absolute quiet was then demanded and the fight was on; and a battle royal it was. For a time, in spite of all I could do, there seemed to be no checking of the flow of blood; and all the time the pulse was getting weaker and more rapid, but at last our sufferer dropped off to sleep and the danger was temporarily over.

Now a new and interesting condition developed. The woman in authority, landlady, I supposed, motioned me out of the room and proceeded to inform me that the patient was tremendously wealthy, that she possessed a plantation in Virginia, the home place, a cattle ranch in western Kansas, and no end of stocks and bonds. She also told me the young lady had no relatives living and was engaged to a young member of the Marion County Bar; that she had made no will, but had stated to her that in case of death, accidental or otherwise, she wished to make the young lawyer, aforesaid, her sole heir. The prospective legatee was out of the city.

The landlady was firmly of the opinion that the patient would not live until morning. "What was to be done in the emergency," was the question propounded to me. I proposed that after a conference with the party of the first part when she awakened, if she so wished, we would send out for an attorney to draw the necessary instrument. She agreed to this shortly thereafter when I explained to her that we did not despair of her life, but were of the opinion that such a course would be advisable.

Everything being satisfactory, I went to my office, promising to return in a short time, and walked away with visions of a glorious fee to remunerate me for my strenuous labors. Returning at the appointed time, I met an attorney, long an honored member of this club, then on the threshold of a prosperous career, who having finished drawing the will, was just leaving. His first question was, "Doctor, can she live until morning?" and then, "She is one of the most remarkable women that I have ever known. She has dictated to me the most satisfactory will I have ever written and that with my ear almost over her mouth, so faint were her whispered words." And then with some words not very complimentary to the legatee as a parting shot, he disappeared into the night.

And a hectic night it was, but the dawn found us still on the job. The patient was sleeping in response to weakness and narcotics, rousing to moments of incoherent whisperings with pinched face, blanched lips, and a rapid, thready pulse, wholly uncountable. But the hemorrhage had ceased and not a moment too soon.

### A Gleeful Ghoul

The first person to make a hurried entrance into my office on the following morning was a somewhat excited individual who took scant time to establish my identity

and introduce himself, His first question was, "My God, Doctor! She can't get well, can she?" And so disgusted I was at the gleeful expression of his countenance and his seeming enthusiasm over his supposedly good fortune, that I told him forcibly that I thought she would, at least if it were in my power to save her.

To make the long story short, the critical days dragged on and became weeks. Occasionally she had returns of the hemorrhage, but not of a serious nature; and all the time our young legal luminary was devotion itself. Flowers and fruits and nurses were furnished, and finally carriages when it appeared that the invalid was sufficiently recovered to take the air as our English friends put it.

One morning several weeks later, he made a second hurried call to my office, and at this time his facial expression was very different from that of his first visit. He requested a private interview and informed me that he had become a bit suspicious of late and had written to the Clerk of the County in Virginia in which his friend was supposed to have a plantation. He had just received a letter in reply stating that no such plantation existed. He had then written a similar letter about the cattle ranch in Kansas and was anxiously awaiting results.

A few days later, a very much subdued member of the bar called on me with the information that the cattle ranch did not exist, and that he had discovered the stocks and bonds were also a myth. With his head in his hands, he confided to me what I was easily able to believe, that he had spent all the money he had, had borrowed all he could, and had gone heavily in debt. All the recompense he had been able to obtain was a proposal of marriage to be consummated immediately or dire results might be expected.

The interesting patient had sufficiently recovered to obtain a clerkship in the legislature then in session, and in view of this I bethought me that it was time to present a bill for my services, which I did. On the following day I received a visit from the lady, who in a very dignified manner expressed her astonishment at the smallness of the amount charged and hinted at wonderful things that were to happen in the near future. She asked, however, to be excused from immediate payment on account of temporary financial difficulties. The temporary difficulties seemed to continue and became chronic. On two or three later occasions I presented the account and always with the same result.

I then turned the matter over to the attorney who had drawn the will, and who promised immediate results. After a visit or two, he admitted his defeat and told me that she had fairly talked him out of the room. As far as I know, the wedding was never solemnized and later she drifted farther afield.

While I was resident at the City Hospital she used to meet me in the hallways when she was calling on friends in the wards, and always with stately dignity and with well-worded salutation greeted me. I was never able to learn anything as to her past history or antecedents. She was well-educated, evidently well-bred, and the coolest female I have ever met. She had deliberately planned the above fiasco when veritably in the jaws of death to insure care and attention while living and a decent burial following her expected demise.

### Good Surgeon or Veterinarian?

I was summoned to the telephone one evening a short time ago and received the startling information that the lady at the other end of the line was admittedly unknown to me; that she had been suffering from a large goiter for some time and had hoped to be able to save up enough money to go to a good surgeon. She had been disappointed, however, and had about decided to come to me. I thought for a moment that the red light flickered a little and burned a shade redder.

I am also reminded that once upon a time I journeyed down to the goodly little city of Greensburg, and from there into the country a few miles to practice my vocation on an ailing old farmer, all upon a hot summer's day. Returning to the station, I entered a day coach of the Big Four Railroad, hot, somewhat disheveled, and bearing the varied impedimenta of my calling. I could see but one-half vacant seat, in the long and commodious car, and noted that

the remaining half of that seat was occupied by what seemed at first glance to be an intelligent human being. First impressions are sometimes misleading. I asked as politely as I knew how, and in fact added a little extra polish to the interrogation, to be allowed to share his seat. The request was graciously granted and then the following conversation ensued:

Question by the seeming intelligent one, "What town is this?" "Greensburg." "How large is it?" "About six thousand." "Live here?" "No." . . . "Where do you live?" "Indianapolis." . . . "That so, I used to live there myself. What's your business?" "I am a doctor." . . . "Veterinary?"

David Harum once sagely remarked that a certain amount of fleas were good for a dog; it made him forget that he was a dog.

### "Bar Sinister" Babies

One of our Indiana doctors residing in Muncie, a town from which nothing but good emanates, has recently sent forth a volume bearing the title, "The Humor and Pathos of Obstetrics." I have not examined the book and therefore am not aware as to just what amount of humor he has been able to find in this primitive and all-important branch of engineering. Personally I have been able to find pathos in plenty, but not much humor.

There was one incident, however, that befell me while resident at our City Hospital which was not exactly humorous, but was at least unique. We always had then, and I presume that they have now, a plentiful lot of unfortunate babies, mostly entitled to the bar sinister, looking for homes. We could supply at a moment's notice almost any color or model of a baby that was called for. The hospital in those days was under the control of a board composed of members of the City Council, and the Board of Health, which is now all-powerful, had nothing to do with its management.

I was called one day by a member of the Hospital Board, a highly-respectable physician of long practice, and asked if I had a brand new baby to give away. On being answered in the affirmative, he earnestly requested that I save it for him and that he would come out immediately. In a few minutes he made his promise good and entered an appearance accompanied by a comfortable female very well dressed, and who presented a front elevation that would indicate to the wayfaring individual that she was about to become a mother. The doctor requested a moment's private interview, after the fashion of doctors when momentous questions are to be discussed.

This is the tale he told: his companion was the wife of a skilled mechanic; they were very respectable people and comfortably well off; he had known them and had been their physician for several years. They had been married for about 12 years and had not been blessed with children, which was a great disappointment for both of them. Some months previous, the wife thought that she had noticed a change in her husband's attitude, which had alarmed her, and learning that babies could be had for the asking at the City Hospital, she adopted the following plan: She broke the joyous news to her despondent husband that she was at last in an interesting condition—and that without doubt, and that furthermore for fear of accidents she must forsake his bed and retire to another apartment. Great joy reigned in the household and all required concessions were cheerfully allowed.

She then applied with timely regularity, padding, in concentric lamellae, over her abdomen, keeping time and size in perfect unison. The momentous hour had now arrived; the doctor and the nurse had been engaged; both gave their approval and entered into the spirit of the occasion; and now the baby was necessary. It was duly produced, 48 hours old, fine and healthy, and the newly-made mother left in high glee. My friend, the doctor, called by phone on the day following and informed me that everything worked out to perfection.

The husband, returning from the shop on call, found the infant in the crib, the mother in bed with the nurse in attendance, and everything to his untutored mind in regular order. Great happiness there was and continued to be, at least for several years thereafter, according to my informant, as long as the family was in his range of information. Was it a square deal? I have my doubts, and lay the soothing unction to my

soul that I was acting under the direction of one of the members of my governing board. It resulted in a happy and contented household; gave a forlorn little chap a good home; and yet I have my doubts.

### Specters of the Past

The disposal of unfortunate babies in those days was a somewhat serious question. I personally investigated every applicant, and many were refused, but when once a proper home, as far as I could determine, was secured, it was found best to keep no record of the transaction. Some years after leaving the hospital, there came into my consulting room one day, a fine upstanding young fellow who stood and looked at me with inquiring eyes for a moment or two, then asked the rather unusual question, "Who am I?" On confession of my inability to make a diagnosis in his case without some laboratory investigation, as is now the vogue, he informed me that a day or two previously he had celebrated his 21st anniversary, and on that day his parents or at least those who up to that time he believed to be his parents and had loved and honored accordingly and with good reason therefor had told him that having no children of their own they had applied to me at the City Hospital in Indianapolis for a baby, and he was that baby.

As far as love and affection were concerned he was their very own, and while it grieved them to disillusion him, yet for fear that later on he might acquire the truth, they thought it was their duty so to do; and further, they had no knowledge as to his real parentage and referred him to me for information. But the desired information was beyond me and he was compelled sorrowfully to go his way.

On another occasion, a well-dressed, and seemingly cultured lady visited me a dozen or more years after I had retired to private practice, and on entering my consulting room burst into tears and with outstretched arms cried out, "My God, Doctor! Where is my baby?" It was the old story, a college girl in a distant city who had loved not wisely but too well and had come to our City Hospital under an assumed name; had given her baby away; returned home; was in time honorably married; but without issue; and now Rachel-like, was mourning for that which could not be restored.

Driving along one of our crowded thoroughfares the other day, I almost brought my automobile back on its haunches, so suddenly did I stop at the sight of a well-remembered figure that I had not seen for years. Somewhat seedy and disreputable he looked as he slowly threaded his way along the sidewalk. His erstwhile flowing black mustache was now white, his shoulders a bit more stooped; and from out his heavy, expressionless face his beady, black eyes glanced furtively to the right and left from under his slouched hat.

The very sight of him brought forth a flood of memories of variegated hue, ranging from near tragedy to comedy. It was Doctor Billy, for many years Professor of Excavation and Extraction on the faculty of the Medical College of Indiana. A very important chair it was, by the way, and one he filled to perfection. He never failed to provide a plentiful supply of dissecting material and had a wonderful technique. I do not believe that the redoubtable Mr. Jerry Cruncher had anything on Bill. He was the most noncommittal soul I ever knew; and in response to my inquiry as to what he was doing; he characteristically replied, "Nothing much"; and it was useless to interrogate him further.

Bill's face was truly his fortune; he had passed through many a third-degree ordeal at the police station and had come out unscathed. When the great State of Indiana finally legalized dissection and provided a means of procuring material therefore without running the risk of getting shot or going to the penitentiary, Doctor Billy's occupation was gone. It is passing strange that so great an artist should have been known and appreciated by only three members of this club; Dr. Ferguson, Dr. Hurty, and myself. Dr. Billy was a pupil of Old Turner, the last of the sextons at Greenlawn Cemetery; and Old Turner was a man of action with great presence of mind. It was said of him that when a famous, or on second thought, infamous, landlady of days gone by planted her foot in the soft earth at the head of a grave in which one of the unfortunate inmates of her establishment had

just been buried, remarking that she intended to come out every day and see if the grave had been disturbed, Old Turner with rare prescience, promptly remarked, "Missy, that footprint of yours is too small; it will soon fill up; let me put my foot in. There, that will last some time, and you can see it easily." And so it did, after a few renewals.

### A Pernicious Practice

Perhaps you will think it a far cry from grave-robbing to fee-splitting, the similarity rests only in this: that the one in its day was a necessary evil; and the other today is an unnecessary evil, that has done much to break down the morale of the medical profession and has submitted the laity to a great deal of unnecessary surgery, performed frequently by incompetent operators. It permitted the tyro and the unskilled to buy business at the expense of the ignorant and unsuspecting. Grave-robbing was a traffic in dead bodies; fee-splitting is a traffic in living ones.

This pernicious practice seems to have originated in Chicago some 25 or 30 years ago, when a surgeon, then in the beginning of his career in which he ultimately succeeded, was endeavoring to break his way into the clientele of the then-reigning favorite. Both were great surgeons, and both have passed on after having done much that will survive. It is said that as soon as our ambitious one had accomplished his purpose, he promptly abandoned the nefarious practice, and after that the very mention of the word had about the same effect on him as the word "wrinkles" had on Beau Brummell.

Fee-splitting spread rapidly; it seemed to permeate the profession from center to circumference; it was a short-cut to prosperity. Many of the older and well-established men claimed that they had to fall in line to protect themselves while the general practitioner who referred the cases smiled complacently and gathered in much easy money. The general practitioner, aforesaid, had long complained of the surgeon getting the fees and of his getting nothing, and looked on the innovation as a step in the right direction. They soon found the man who would pay the biggest price, and



then got out and hustled for business. Many border-line cases with shady diagnoses were operated by some surgeons when such proceedings were not necessary in order to save the faces of their friends who were sending them business. The conscience of the profession seems to have taken a big slump.

It was at this time that the saving element came to the rescue and founded the American College of Surgeons through whose portals no fee-splitter can pass. The college has done and is doing a wonderful work, and fee-splitting is slowly but surely passing out. We still have them with us, good, bad, and indifferent; but the work of reformation goes steadily on; and I hope that in the near future no surgeon will be allowed to operate in our hospitals or belong to our societies who is guilty of this pernicious practice. I do not wish to convey the impression that all surgeons who do not belong to the American College are fee-splitters, far from it. It is safe, however, to infer that those who do belong are not guilty. It would also be far from my intention to accuse all general practitioners of being particeps criminis, but is it true that the practice spread like a pestilence and

did not seem at all selective in its victims.

I presume that it is fair to admit that it is the unexpected which happens to persons in any walk of life, but I am inclined to believe that unlooked-for conditions and incidents are found to a greater extent in the daily life of the surgeon than in any other calling. He is trained for this and must be ready for any emergency at a moment's notice. Surprises must have no terrors for him.

Answering a hurried call to a hospital a few years ago, I found a pale-faced, quiet figure on the table in the emergency room, stripped to the waist and covered with towels. The awe-struck appearance of the nurses and house doctors, something unusual under ordinary circumstances, elicited a questioning glance on my part. "Lift the towel, Doctor," was the answer; and then I saw what I have never seen before or since.

The poor fellow had been caught between two cars moving in opposite directions and his chest had been so torn open that his heart was completely exposed to view, beating away regularly in its pericardial covering. Strange to say, he was thoroughly conscious although pulseless. It has been my custom for many years to call hurt railroad men Democrats. It is a euphonious appellation of honest Greek origin and supposed to be non-irritating. It is further applicable because fully 75% of these men were so classified on the poll books.

My first order to the house surgeon was, "Hurry up, Doctor and let's get some normal salt solution into this Democrat or he will get away from us." As I turned from the dreadful but fascinating view to assist in the procedure I had ordered, I heard a low chuckle and turning found the injured one laughing. Then in a low whisper, he said, "Say Doc! How did you know I was a Democrat?" With these last words on earth, and with a smile on his lips, I saw his heart, poor, much-abused organ that it was, faithful to the end, shut up like a closed fist and open no more. Since that event I have been a bit careful about calling a badly-hurt man a Democrat.

### Monomaniacal Mail

It has been my good fortune to have been the recipient of a great many queer letters. They have certainly added variety which is supposed to be the spice necessary to well-ordered human existence. For several years in succession, I received well-written epistles from a poor woman, no address ever given, imploring me to send her the proper medicine or agent of any kind with which she might combat the evil machinations of her neighbors who were slowly but surely killing her by telepathy.

Another one, and one was enough, was received from a versatile crank living in a small town in the southern part of the state, who was openly looking for trouble. He premised the real essence of his letter by stating that the medical profession had unanimously concluded that the vermiform appendix was of no anatomic or physiologic significance and was only good to the surgeon from an economic standpoint. It was, in fact, a real meal ticket to the impecunious practitioner. He had discovered, however, that the vermiform appendix was a wonderful organ, the functions of which had been woefully overlooked, and that the human race was suffering greatly from its ruthless removal. He then gave an accurate description of the organ, its location, nerve and blood supply, preliminary to launching into a description of its real functions, which were as follows:

Being a tail-like affair, its length varying as to the size of the abdomen in which it was to functionate, it was intended to lash about among the viscera, stimulating the splanchnic nerves, and through them all the vital organs. But above all, to titillate and massage the undersurface of the liver, which was nature's way of overcoming the natural tendency of the human race to melancholia, and that no person who had had his appendix removed could expect to be happy and carefree again. He know this to be true from his own personal experience, and that he intended to sue the surgeon who had thus ruined him, for malpractice, and besought my kindly assistance in so doing.

The following Macedonian cry for help contains hardly a single properly-spelled word, and yet it came from a doctor, practicing in a small town, not very far distant from that Athens of Indiana, classic Crawfordsville:

"Dr. John Oliver, M.D.
Indianapolis, Indiana
Dear Sir:

"I want your advice about a patient of mine that is very bad off and is the son of a rich citizen of this here county and having lots of influence. I hate to lose him and then he says he won't pay me if he don't get well or dies. I think he was took with consumption first as the top of his lung was powerful sore and he was confined two or three days before I could see him on account of my horse who has been very sick. I couldn't seem to do nothing for him, and now his stomach tube seems to be rotted off. Let me hear from you quick, and will you kindly send me a list of your prices because I want to be sure to get all that he owes me before he dies.

"Fraternally yours in trouble,
Dr. Blank, M.D.

"P.S. Please excuse penmanship and bad writing."

It is difficult to cull from the accumulated experiences of years the happenings and events that are apt to be of interest to the club. Many great discoveries and innovations that mark epochs have come to us since I first lighted the "red lamp" in my hallway.

It was my good fortune to be the house surgeon on duty at our City Hospital on the service of the late Dr. John Chambers, one of the brightest young medical men that ever came to the city of Indianapolis, long since gone to an untimely grave, when antiseptic surgery had its birth in that institution and in the city and state as far as I know. Our efforts were crude, very crude, as compared to the perfected technique of the present day; but one of our first cases, a thigh amputation, went home well at the end of two weeks, a result which we have never been able to improve on very much. Stimulated by the results following clean surgery, our surgeons were at that time just beginning with timorous fingers to invade the then-sacred precincts of the abdomen. How different from the present when the operating schedules of our combined hospitals will show a score or more of these operations in a single day.

It was my good fortune to perform the first successful operation for gunshot wound of the intestines in our City Hospital, although the late Mr. W. P. Fishback had informed me in his kindly way that such a thing was impossible. Mr. Fishback was a very versatile man; this is no news to the older members of the club. There was nothing going on in our city, of any importance in his time, in which he was not interested. He had heard somehow of one of my abdominal gunshot cases of some importance that had resulted fatally, as they all had up to that time, and had stopped me on the street to tell me not to feel badly about it because the Lord never intended a man shot through the guts to get well. Unfortunately, he passed on just before my first successful case, following which there were three others in close succession, all successful. It would have given me great pleasure, had he lived, to have reported them to him.

In the train of antiseptic surgery came aseptic surgery, one simply a refinement of the other; and then the roentgen ray with its revolutionizing results, and serum therapy and radium, and many other things of less importance, and connected with each some interesting reminiscence all untellable for lack of time.

In his preface to his "RED LAMP STORIES," Dr. Doyle remarks that "a tale which may startle the reader out of his usual grooves of thought and shock him into seriousness plays the part of the alterative and tonic in medicine, bitter to the taste, but bracing in the result." With this text for an excuse, it is my firm intention to bring these ramblings to a close with just one more tale—just one—with the hope that this announcement will counteract the bitterness already engendered and act as a tonic which will brace you up and enable you to exist unto the end.

### Judicable Judge

It was my good fortune some years ago, quite a number of them, in fact, to spend a few weeks recreation-bent with an old student and friend of mine practicing medicine in a rapidly-growing little city, a county seat, nestling in the foothills of the Rockies, in one of our then newly-born states.

Shortly after my arrival and while lounging about the doctor's office, as I was wont to do between hunting and fishing expeditions, I had the pleasure of meeting with the judge of the County Court, a fine, upstanding chap whom the doctor informed me had already crossed the Biblical deadline without seeming injury in the transition.

He was suffering from a rather painful malady, for the relief of which I was pleased to suggest a simple operation which gave him great relief and established me firmly in his good graces. There seemed to be but little known of his antecedents. As one citizen informed me, "He was here when everybody else came." The judge was quiet and reserved in the main, an excellent listener, but when stirred into active conversation, proved a fluent talker especially rich in the lore of pioneer days. He had taken Horace Greeley's advice and had gone West when a young man; entered, proved up, and purchased valuable lands; had raised both cattle and sheep; and practiced law on the side when practice was to be obtained.

He had been a justice of the peace in territorial days, and had been fully able to enforce the rules of his court, both by western and eastern methods. With the advent of the state courts he had been elected judge, and judge he had been ever since. No one had ever thought of opposing him in his own party, and his party was paramount. He had married and reared a family. His wife had died a few years before; and his sons and daughters had married and dispersed, but he still continued to live in the fine, old country house in the edge of the city. I have never met up with mortal man who seemed so universally loved, honored and esteemed. He had refused other preferment many times; might have been governor or congressman at will, if he had so desired; but he would have none of them. A judge he was, and a judge he had remained.

Some months previous to my visit, a very popular young man was found murdered under circumstances that strongly implicated a rather ne'er-do-well, young chap, who had been or thought he had been a rival in a campaign for the good graces of one of the city's fair belles. The suspected murderer had, after a few days, been arrested; and the detective force of the city was able to weave about him such a web of circumstantial evidence, and circumstantial only, as to leave but little doubt in the public mind as to his guilt. The case came up for trial during my visit; and much to the surprise of everyone our judge seemed to lean strongly to the side of the defendant from the beginning. Objection by counsel for the defense to evidence introduced by the prosecution was sustained by the court if there was any plausible excuse therefor, so it was claimed. His instructions to the jury in which he discussed the reliability of circumstantial evidence and its value were strongly in keeping with his rulings during the whole course of the trial.

The jury retired; returned a time or two for further instructions; and finally, after a long and tedious wait, agreed to disagree and were discharged. The failure of the jury to agree was attributed to the attitude of the judge, and raised a storm of indignation and disapproval that was voiced by press, pulpit, and populace. It was with difficulty that the judge's closest friends could find grace of heart to defend him, and our idol of yesterday was suddenly cast down from his pinnacle of public supremacy by a whirlwind of public condemnation.

Doctors as a rule are not easily stampeded if imbued with the real medical diathesis, and my host never for a moment lost faith in his friend. An evening or two after the storm broke found us wending our way out to the judge's home to assure him of our unabated esteem and confidence, and comfort him with the spoken word. We found him sitting on his front porch facing the west alone with himself and his pipe.

It was one of those rare evenings in the early summer when all nature seems in accord and at rest. Out in the west the sublime, sweet evening star, embowered in faint tints of purple and gold, was slowly sinking to rest behind a far-distant line of snowcapped mountains that formed a silver ruffle of wondrous lace that bound the distant edge of the horizon. I never experience such an evening without recalling Lew Wallace's description in *Ben Hur* of the night of the nativity.

"There was no wind; the atmosphere

seemed never so pure; and the stillness was more than silence; it was a holy hush, a warning that heaven was stooping low to whisper some good thing to the listening earth."

Our friend received us with his accustomed kindly dignity. He seemed in no way disturbed by the wealth of adverse criticism to which he had been subjected; in fact, he did not refer in any way to the doings of the last few days, but sat, slowly smoking his pipe and contemplating the starry grandeur of the western heavens which, with the dying afterglow, progressively grew in scintillating brilliance and beauty until the firmament seemed paved with a luminous mosaic of silver and gold.

### A Morose Monologue

I cannot, or course, remember exactly what he said. His words came slowly and much in the nature of a disjointed monologue, although I noted down as much as I could remember a little later and linked it together as well as I could. The immensity of the universe appalled him, not our comparatively little solar system, but the unnumbered others of which our finite minds could have no conception. He liked the sacred name Jehovah in preference to God because no one knew its origin or from what language it sprang. He liked to think that it had always existed and was likewise imperishable. It rang true with the great doings of the Old Bible; it fitted in with a concept that in a way he could grasp, a great entity comprising everything.

The truths of the New Testament were hard for him to embrace. The teachings appealed to him. They were grand in their breadth and comprehension. But in spite of himself, the Christian religion at times seemed small and circumscribed and out of keeping with the magnitude of the universe. But when doubts came thick and fast, he fell back on a favorite thought from Browning,

"The sum of all is Yes, my doubt is great, my faith's still greater."

He seemed for a time to lapse into a profound revery, and finally rousing himself with an effort, began the following remarkable recital; speaking in a low voice with frequent pauses as if the events were painful to recall, and at times with apparent evidence of subdued emotion.

He was born in one of the larger New England towns. His father was a distinguished member of the bar and was descended from stern New England ancestors, possessing much of their hereditary austerity and straight-laced religious beliefs. He had no brothers or sisters and his mother had died in his early boyhood. The relationship between himself and his father was never very close, especially after he had become a bit wild and intractable. He was educated in one of the great universities and was graduated both in letters and the law.

On returning home he entered his father's law office, but the tendencies of his youth had not been improved by his college education, and his escapades led to frequent altercations with his father which endangered his position in the office. His reputation in the community soon began to suffer and finally sank to about the same level as that of the defendant in the trial of the previous week. Now he was sure that there had been nothing vicious in his make-up. It was rather a full red-blooded desire for fun and excitement which occasionally, with the aid of alcoholic stimulants, outran the bounds of New England conventionality and reason.

It was the same old tale, the intensely proper young business man and the young rake, both suitors for the same lady's hand in which the wild one had the seeming advantage as is frequently the case. The father and mother of the young lady, however, would have none of him. The daughter was dutiful, and the sacrifice was made. On the occasion of his last visit, he found his successful rival in undisputed possession, so sure of his triumph that he soon left, pleading a pressing business engagement. After a brief and tearful interview, the vanquished rival took his final departure, sad and dejected. While walking homeward, he was startled by a cry for help coming from down a side street that he was about to cross, and turning, saw by the light from a coal-oil street lamp two men struggling some distance away. Running thither, he saw one of the men break loose from the other and strike his opponent down with a heavy

weapon of some nature, then turn and run rapidly away.

On reaching the fallen one and turning him over, he was horrified to find him dead. Evidently the skull had been crushed by the blow — and a moment later, to discover in the person of the murdered man his successful rival. He was carrying that evening a heavy, blackthorn stick which he dropped by the side of the murdered man as he stooped to examine him. Just as he was arising from his investigation several men ran up, and among them a policeman, who recognizing our wild young lawyer, promptly placed him under arrest as the murderer.

Briefly, he was arraigned, tried for murder, convicted and sentenced to the penitentiary for life. The cane which he had dropped, now stained with blood, was introduced in evidence as the instrument of destruction. It was argued that he had left the home of his lady friend with premeditated murder in his heart; had followed his victim; and had struck him down in cold blood. Nothing but the reputation of his father, his youth and the straight-forward story he told on the witness stand, which the prosecutor could not shake, saved him from the gallows.

His father was early convinced of his guilt and pleaded with him to confess it; and when he flatly refused to do so, practically deserted him. It was useless for him to try to describe his state of mind as he departed to the penitentiary, manacled to the sheriff. All hope had deserted him, and the only problem left to solve was how to commit suicide. An hour or two after he started on his journey for what he supposed was a living death, and while the train was running rapidly through a somewhat lonesome bit of territory, there came a sudden crash, a sudden stoppage, a rending and grinding of everything about him, mingled with shouts and cries and pandemonium generally. He found himself practically hanging by his manacled wrist, still firmly attached to that of his convoy, half in and half out of the car which was resting partly on its side.

He soon discovered that the sheriff was crushed to death over the arm of the seat by the descending car roof which had caught all the passengers sitting next to the aisle, when the side of the car in which they were riding was torn out. The forward car had jumped the track and turned over. The rear car plunged on, and telescoping the two forward ones, had practically torn the whole train to pieces. He had been contemplating death as a blessing, and now found it all about him. Here he was, barring a few scratches and a contused wrist, unhurt. The crackle of flames soon began to add a new terror to the situation as the upturned stoves quickly set fire to the wooden cars.

### Macabre Machinations

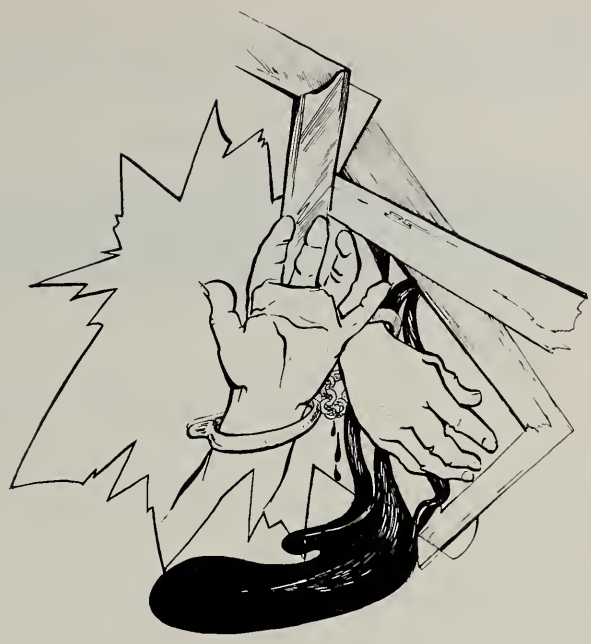
A desperate tug at the handcuffs quickly showed that nothing short of an amputation could free him without their removal. Luckily, he remembered that the sheriff's keys were in his right-hand coat pocket; and dragging himself up under the crushed body, still partly supported by the car seat, he was able to procure the coveted bunch and immediate freedom. Then he had an inspiration when he saw the arm of the man who had been sitting on the inside of the seat immediately in front of his dead companion, extending backward under the body. On his unresisting wrist he quickly snapped the steel bracelet. He had little difficulty in getting out of the wrecked coach and found a number of other passengers running hither and thither in a more or less dazed condition.

It was with difficulty that he resisted the temptation to be off immediately. As quickly as he could, he organized the uninjured ones into a relief squad and made such efforts as were possible to rescue those still living, but with little success as the flames by this time had gained such headway that the heat was unbearable. Fortunately, the engine had not left the track, but had broken loose from the train and now hurried to the nearest station to summon relief. He soon saw it returning loaded with men; and as there was now help aplenty, and but little to do as the wreck was well-nigh consumed, he decided to make his escape and found no difficulty in stealing away unobserved through a

woodland that bordered the railroad track. There was another railroad a few miles distant, and towards this he bent his steps, intending to catch a train at the nearest station. Walking rapidly along, dazed with his new-found freedom, it suddenly dawned on him that he had no money.

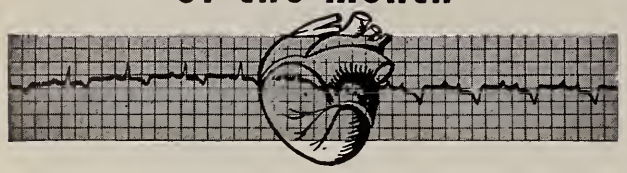
Sitting down to rest and think over the situation, he remembered a small package that he had in his pocket, which his father had given him the night before when he came to tell him good-bye. In it he found a Bible, and a letter urging him to confess, and as great good fortune would have it, one hundred dollars in bills. This money enabled him to make his way to New York where he read in the morning papers a full description of the horrible wreck and how, among other things, they had found the charred remains of the faithful sheriff still manacled to the prisoner. From New York he went to Chicago where he obtained employment for a time, and then westward. "Out here I prospered, and it is not necessary that I tell you of my prosperity.

"I have always intended to tell my story to some one, and I guess its about time I did. It has seemed to me at times that I must tell it, yet I never could tell why. I should have told my good wife, and so intended to do, but she passed on before I could gain sufficient courage. My friends, I have perfect confidence in your loyalty and discretion, and I am glad the ordeal is over. I shall not seek another election, I do now know," and he paused apparently in trouble,



and then without another word he collapsed and fell over the left side of the chair in which he sat, and his pipe falling from his paralyzed hand, clattered on the floor. We sprang to his assistance and carried him into the house, summoning his housekeeper. There was no doubt as to the trouble. The purple face; the flapping cheeks; the widely-dilated pupil; the rackety, irregular respiration; the slow, full pulse; the sour smell of impending dissolution; and the line of foam forming on the lips told the tale. "Hemorrhage into the right ventricle," I involuntarily exclaimed, and "Thank God, a kindly big one!" was my friend's reverent reply. ◄

# Electrocardiogram
## of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Effect of Quinidine on the SA Node and A-V Transmission*

*CHARLES FISCH, M.D.*
*Indianapolis*

PROLONGATION of the QRS interval is a well recognized sign of quinidine toxicity. Fatalities during quinidine therapy are usually ascribed to a marked depression of intraventricular conduction, manifested by extreme prolongation of the QRS and usually followed by ventricular arrhythmia or standstill. Depression of pacemaker activity (S-A node) and A-V conduction (prolongation of the P-R interval) are not widely appreciated as serious signs of quinidine toxicity. The purpose of this report is to present an instance of depression of these specialized conduction tissues without any evidence of prolongation of the QRS.

Tracing taken on 3-8-64 (Figure 1) shows a prolonged Q-T interval (best seen in V-3), a P-R interval of 0.36 seconds, runs of SA arrest (II, V-3) and S-A arrest with A-V nodal escape (third QRS in AVR). After the quinidine was discontinued, the SA depression was no longer in evidence and the P-R and Q-T intervals gradually returned to normal (2-10-64 and 2-15-64).

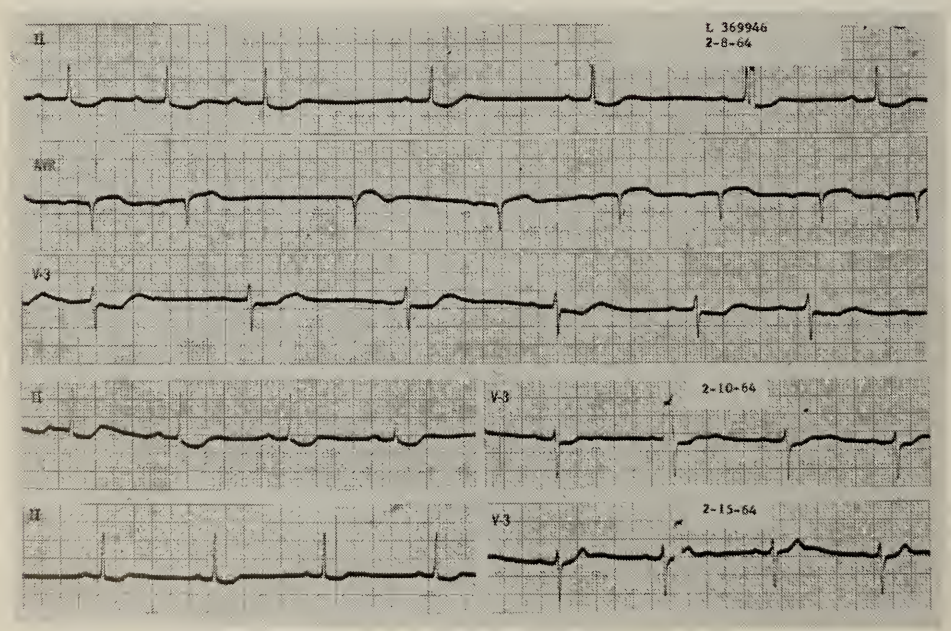



**FIGURE 1**
**THESE tracings show the effect of quinidine on A-V transmission. For details see text.**

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Lipoid Pneumonia

ERICH K. LANG, M.D.*
*Indianapolis*

AN 82-year-old white male was first admitted to the Johns Hopkins Hospital in 1955, with the diagnosis of a mass lesion in the posterior segment of the right lower lobe. The referring physician stated in his note that the patient had been seen for a "chronic pneumonia" for the past two months. The patient was known to be a heavy smoker and had consumed in excess of two packs of cigarettes a day for the past 15 years. During the past eight months, a chronic non-productive cough had developed and slightly blood tinged sputum had been noted on occasions. The patient had lost 15 pounds during the past year. Physical examination and history were unremarkable with the exception of chronic constipation, which had plagued the patient for over ten years.

A comparison of serial outside and present films, covering a period of eight months, revealed a mass in the posterior and mediocaudal segments of the right lower lobe. The hilum was unremarkable. Laminograms demonstrated a near homogeneous density of the mass and lack of enlarged nodes in the hilar area. Bronchoscopy showed a slit-like narrowing of the segmental bronchi of the posterior segments and medio-caudal segment of the right lower lobe. Bronchial washings showed a "histologically grade three cell type." This is considered a borderline classification, given to both chronic inflammatory cells as well as relatively well differentiated shedding tumor cells.

* Department of Radiology, Methodist Hospital, Indianapolis.

In view of the ominous history and appearance of the roentgenograms, a thoracotomy was performed. A mass was readily encountered, grossly resembling a bronchogenic carcinoma. A lobectomy was therefore carried out. The hilum was palpated and felt to be innocent.

Histologic section revealed the classical findings of a lipoid pneumonia. Even on gross section, small drops of fat could be expressed from the cut surface. In retrospect, a history of habitual use of mineral oil for ten years was obtained.

## Discussion

Lipoid pneumonia will often mimic bronchogenic carcinoma. Radiographically, the entities are difficult to differentiate. Bronchogenic carcinoma will usually show lymph node masses in the hilum or in the carina. Moreover, meticulously performed bronchograms will frequently demonstrate the classical cut-off of a bronchus by the bronchogenic carcinoma or direct invasion of the bronchus by the tumor mass. Conversely, lipoid pneumonia will show inflammatory changes of the bronchial wall, but normal patent bronchi.

The most significant point of differentiation between these entities lies in the examining physician's awareness of lipoid pneumonia and his careful perusal of the patient's history for the use of mineral oil or oily nose drops. In the older age group, these media will frequently cause lipoid pneumonia, particularly after prolonged chronic use. ◄

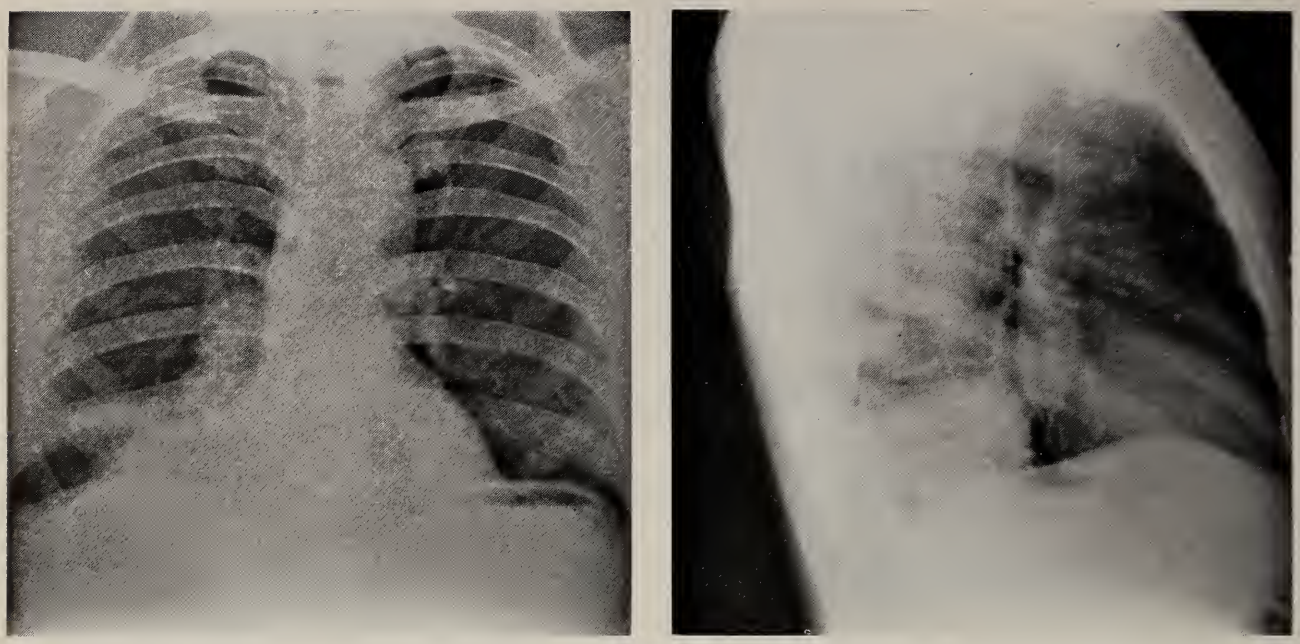
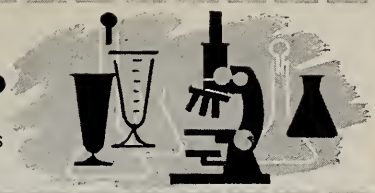


FIGURE 1 (A and B)

THE PA and lateral projections demonstrate a discrete mass in the posterior and medio-caudal segments of the right lower lobe. The homogeneous density and discreteness of the mass suggests a bronchogenic carcinoma. There is a significant absence of hilar manifestations. The right hilum, as far as demonstrated, is entirely normal.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



**This new series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It will be edited by Leon L. Blum, M.D., Terre Haute.**

# *Differential Diagnosis of the Month:* HEMATEMESIS

*WEI-PING LOH, M.D.**
*Gary*

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| *Clinical data:* | A 25-year-old bartender who had a history of chronic alcoholism suddenly became dizzy and collapsed. He also vomited dark red blood. Further inquiry revealed that he had had frequent episodes of epigastric pain which he attributed to the drinking of cheap wine. |
| *Physical examination:* | He was pale, cold and clammy with a blood pressure of 70/30 and thready pulse of 98 per minute. His breathing was rapid and shallow. There was mild tenderness at the epigastric region. |
| *Laboratory data:* | Hemoglobin: 8.0 gm. (cyanmethemoglobin method), red blood count: 3.0 million, hematocrit: 26 and white blood count: 12,000 with a slight increase in band forms.<br>Blood smear: one plus hypochromia. Platelets adequate or slightly increased.<br>BSP: 18% retention at 45 minutes, BUN: 40 mg.%, and total serum bilirubin 1.5 mg.%.<br>Urine: essentially negative.<br>Stool: tarry and positive for occult blood. |
| *Consultation note:* | A gastroenterologist was consulted and he agreed with the attending physician's diagnosis of active hepatic cirrhosis complicated by bleeding esophageal varices. He advised blood transfusions and conservative treatment. |

* Chief Pathologist, Methodist Hospital of Gary, Inc.; Asst. Professor of Pathology, Chicago Medical School.

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| *Follow-up:* | The patient developed abdominal pain and shock became more severe. His epigastrium was rigid and markedly tender. An emergency abdominal laparotomy was performed. The surgeon found a bleeding duodenal ulcer with perforation. The patient's liver was slightly fatty but was not grossly cirrhotic. There was no evidence of bleeding esophageal varices. The duodenal lesion was resected and the patient made an uneventful recovery, although his course was quite unsure at the time of surgery. |
| *Interpretation:* | The attending physician and the gastroenterologist overemphasized the history of chronic alcoholism and the BSP retention. They apparently overlooked the fact that the BSP retention in this case was caused by shock with slow blood circulation through the liver. While BSP is a good screening test for liver function, the test is quite non-specific and increased BSP retention does not always mean hepatocellular damage. Furthermore, no other liver function tests were performed in this case and it was unwise to reach a conclusion of hepatic cirrhosis on the basis of the BSP test alone.<br>The patient's blood picture is compatible with acute hemorrhage superimposed on chronic blood loss.<br>The increase in BUN and total bilirubin was most likely due to absorption of extravasated blood and blood pigments from the intestinal tract. Pre-renal azotemia on the basis of shock could also contribute to the increase in BUN. ◄ |

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*Devoted to the interests of the medical profession of Indiana*

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# Health Care of the Aging in Indiana

TESTIMONY by Dr. N. L. Salon, Fort Wayne, on the subject of health care of the aging in Indiana before the Congressional Committee on Aging provides an excellent summary of the progress made in this field during the past ten years by the ISMA Commission on Aging, the Governor's Commission on Aged and Aging and lately by the Joint Council for the Improvement of the Care of the Aged and Aging of which the ISMA is a part and which was first organized by the ISMA.

Dr. Salon described the formation of the ISMA Commission on Aging in 1956. He emphasized that one of the first and important objectives of the committee was "Raising the standards of administration and patient care in the various kinds of institutions presently engaged in caring for the aged and chronically ill."

The committee early recommended and obtained transfer of the licensure of nursing homes to the State Board of Health. After visits to many public and private institutions, it conducted a public education campaign which was highlighted by a well attended public hearing in Fort Wayne.

One of the principles of the ISMA Commission and of the Governor's Commission on Aged and Aging has been that of independent living. Efforts are made to prevent the institutionalization of the elderly who are ill, and efforts are made to return them to private homes as soon as possible in case institutional care is temporarily necessary.

Both commissions believe that the aged do better both physically and mentally when they can be cared for in private homes.

An official survey of county homes has shown that many were delapidated and many had no medical supervision. These deficiencies are being remedied in some instances by closing the homes, in others by effecting physical repairs and by providing medical programs.

Rehabilitation is being stressed. Twenty percent of the individuals in county homes and 12% of those in nursing homes can be returned to private life if rehabilitation services are available. The Home Care Program is being utilized to provide the aged sick with the best care possible.

The ISMA Commission is also encouraging the cooperation of general hospitals and nursing homes with mutual advantages to both. In this arrangement the hospital furnishes the advice of its many management and therapeutic specialties and the nursing home is upgraded to the extent that it is able to admit many of the long-term or convalescent hospital patients.

The nursing homes of Indiana are being

transformed from custodial institutions to facilities for treatment, convalescence and rehabilitation. The activities of the ISMA Commission on Aging and of the Governor's Commission on Aged and Aging have resulted in the use of these facilities for the care of many more people who formerly would have had to use the facilities of an acute hospital. This would help relieve the hospital bed shortage.

The more the nursing homes and county homes can be used to house and treat the aged according to present day standards, including rehabilitation technics, the more will these individuals be returned to private life and the less will be the need for building more institutions.

## Community Health Week

THE May-June issue of the AMA "PR Doctor" features an article on Community Health Week which will be observed this year from November 7 to 13.

Purpose of the special week is to acquaint the public with the many societies, health groups and agencies which are teamed up for better health. County medical societies make good spark plugs for such programs. Now is the time to make plans.

Activities which may be engaged in by the various health agencies for the purpose of public education are almost endless. The "PR Doctor" story outlines many of the activities which were adopted by medical societies all over the United States last year.

Greensburg and Decatur County in our own state are accorded complimentary mention for their public health forum, newspaper ads and distribution of brochures and health education packets.

Other localities over the nation conducted hospital open houses, health fairs, immunization clinics or health hazard campaigns.

The AMA Community Health Week kit, including a reprint of the above mentioned article, will be distributed to county medical societies on August 1st.

## Dr. Kenneth E. Penrod, New I.U. Provost

RECOGNITION of the complexity of administrative functions in the Indiana University Medical Center in Indianapolis has prompted the appointment of a major administrative officer with the title of provost.

Dr. Kenneth E. Penrod, former vice-president for medical affairs of West Virginia University, assumed the post July 1.

Dr. Penrod is a native of Ohio. He received a B.S. degree at Miami University in Oxford, Ohio in 1938 and the Ph.D. degree from Iowa State University in 1942. He served as an aviation physiologist in the Air Corps from 1942 to 1946, and was then assistant professor of physiology at Boston University School of Medicine until 1950. He was a member of the faculty of Duke University School of Medicine for nine years and was assistant dean there from 1952 to 1959.

He has been at West Virginia University since 1959 and won the admiration of President Elvis J. Stahr, then president of West Virginia, for his splendid administrative work in the formation of their new medical center.

The Medical Center in Indianapolis, with its medical school (one of the largest in the country), its dental school, the nursing school and the Division of Allied Health Sciences, presents an immensity beyond the resources of even the most talented and energetic trio of deans.

The group of University hospitals is growing each year. The new additions to Riley Hospital and a new teaching hospital now beginning construction are, no doubt, only a portion of future expansion. The teaching functions of the schools and hospitals for medical students, dental students, student nurses, interns, residents, therapists and technicians of more than a dozen varieties, as well as postgraduate teaching programs for the physicians of the state, intertwine and doubtless, at times, interfere with each other in a network of administrative machinery which requires

and will require more in the future, the steady hand of a master regulator and moderator.

And, if the Medical Center had no teaching functions at all it would still be involved in the intricacy of tasks of caring for a multitude of patients both in the hospitals and in the out-patient clinics, many of them receiving the benefits of advanced technics and of new and expensive equipment.

The research programs grow each year with increased support from private philanthropy and from governmental sources.

A dean of a professional school functions best in his primary role when he is relatively free from administrative duties. The deans of the schools of medicine, dentistry and nursing of Indiana University will find that they have more time for their academic mission and a more peaceful atmosphere in which to work when a portion of the details of management have been lifted from their collective shoulders.

Everything runs better when the administrative machinery runs smoothly.

## Editorial Notes...

**Unrecognized human leptospirosis was the subject of discussion at the recent annual meeting of the American Veterinary Medical Association.** Tjalma and Galton reported that as many as 10% of cattle and swine have the disease. With so much close contact between livestock and humans, an easily transmittible disease such as leptospirosis should and probably does occur oftener than is reported. Pomona is the common strain. Jaundice is usually considered essential to the diagnosis in man but the authors mention that this is true only with the Icterohaemorrhagiae strain, not with Pomona. Refer to an interesting paper on the same subject by Dr. Margaret Bassett on pp. 737-740 in this issue.

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**Loans to medical students, interns and residents by the AMA-ERF Loan Guarantee fund were greater in number in 1964 by 13%.** Since the start in March, 1962, 19,298 loans have been approved for a total principal value of more than 22 million dollars. The I.U. School of Medicine was third in the nation in number of loans (222) in 1964. Texas (Galveston) and Tennessee were the leaders. Loans to residents increased more in 1964 than loans to students and interns. The fund should reach the self-sustaining stage by 1970, when payments will equal the new loans and interest payments will offset the defaults. Estimate of the guarantee fund in 1970—six million.

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**Nursing school admissions in the United States were up in 1964 to 92,300, 12.7% over 1963.** The increase is due largely to the post-war "baby boom." Both professional schools and schools of practical nursing shared in the new record number of admissions. The National League of Nursing reported that even this improvement in new nurses is not enough; the country should have 75,000 to 80,000 annual admissions to professional training, in addition to more practical nurses. Stated in another way—nursing schools should attract six percent of all girl high school graduates instead of the present five percent. Also needed: either more nursing schools or bigger nursing schools, or both.

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**Tissue reactions to drugs will be registered and studied by the Armed Forces Institute of Pathology (AFIP) in accordance with arrangements made by the AMA, the FDA and the Pharmaceutical Manufacturers Association.** Autopsy or biopsy specimens will be submitted for the centralized and authoritative study by AFIP pathologists which is characteristic of the 28 Registries already maintained by AFIP. Results of the studies will be reported back to the originating pathologists and will also be summarized in periodic reports.

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**Ninety hospitals in the United States operated an entire year with a perfect employee safety record.** In 1964, nearly 78 million injury-free man-hours were recorded by these hospitals. The record was set in the annual contest for employee safety conducted by the American Hospital Association and the National Safety Council. Three hundred and sixty-five hospitals entered the contest. The VA Hospital in Columbia, South Carolina won the grand

award due to its perfect record and the fact that it had the greatest number of injury-free man-hours since its last reportable injury.

**There are 545 poison control centers in the United States.** These are all listed by location and with necessary operative information in a directory published by the U.S. Public Health Service. All centers listed function independently within state control programs. They are all supported with information and technical data services by a national clearing house, a part of the USPHS, and can be called anytime, day or night, for information concerning the identification of poisons and the proper treatment of poisoning.

**The Greene County Medical Society "Singing Doctors" of Springfield, Missouri, who were honored guests and "entertainers extraordinary" at an ISMA Annual Convention several years ago, have assisted three dozen medical students with their education.** Over $75,000 has been grossed from the sale of three record albums containing 60 parodies which make up the unusual musical show which has been presented before 40 state and national medical meetings. The scholarship endeavor continues. The society plans to assist hundreds of young men and women in the future. ◄

## About Our Cover



There are approximately 5 million individuals in the United States today who have, at some time in their lives, been diagnosed as being retarded; approximately 126,000 more are born each year.

And there are untold thousands who go through life never having been definitely diagnosed as being retarded.

The general practitioner today sees an increasing number of these children because of improved infant salvage and the greater emphasis on keeping the retarded in the community.

Early diagnosis by the physician permits identification of a retarded child. This institutes the beginning of helpful therapy.

The physician continues to play a unique role through the years of a retarded individual's life, serving as counselor, providing information for the family and suggesting referral to other community services.

To aid the physician in meeting this overwhelming responsibility, the American Medical Association, through its Council on Mental Health and Committee on Maternal and Child Care, invited some 175 experts on retardation to recommend guidelines for the practicing physician.

Meeting in April, 1964, these experts produced recommendations which are a basis for the handbook, "Mental Retardation—A Handbook for the Primary Physician."

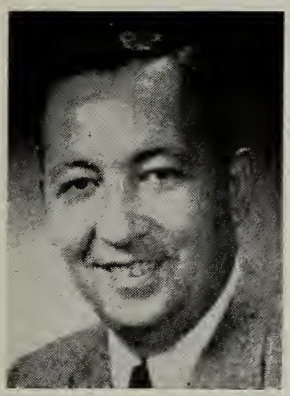
This handbook is now available on request from the AMA. It is designed to be of aid to all physicians who are in contact with a retarded child and his family and covers diagnosis, management and prevention. Also included are listings of supportive services available to physicians for retarded patients at successive ages.

Our thanks to the AMA for making this month's cover available to us.—J.F.S.

# President's Page

June has passed and with it the annual convention of the American Medical Association in New York City.

One of the predominant issues, of course, was the profession's concern with "Medicare." After conscientious study of the various resolutions which had been introduced on the subject by the House of Delegates' Reference Committee on Legislation and Public Relations and testimony from at least 100 physicians, the reference committee reaffirmed, in its report, Section 6 of the Code of Ethics which states that "a physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care."



In addition to endorsing the reference committee's report, the AMA House of Delegates reaffirmed the Bauer Resolution adopted in June, 1961, which reads as follows: "The House of Delegates of the American Medical Association believes the medical profession will see to it that every person receives the best possible medical care regardless of ability to pay and it further believes

"That the medical profession will render that care according to the system it believes is in the public interest and that it will not be a willing party to implementing any system which it believes to be detrimental to the public welfare."

The Indiana delegation introduced resolution 49 which states the following:

"Resolved that the physicians of this nation adopt the same position for payment of their services as other purveyors of goods and services under federally supported programs; and be it further

"Resolved, that physicians inform all third parties that effective January 1, 1966, physicians will participate only on the basis that they receive their usual and customary fee for like services as paid for by the private paying patients."

Concerning this second resolve, an effort was made to modify a reference committee revised resolution by inserting, with the terms "usual" and "customary," the term "reasonable." Reasonable was well-defined by the other group of physicians which wanted to make the insertion, but the Indiana delegation was most effective in preventing this amendment from being passed. It was their feeling that the word "reasonable" has a connotation not always understood by other parties and which would leave room for broad interpretations. The revised resolution did not set a specific date.

I would like to remind the membership that on July 17 in Indianapolis, the Council of ISMA will meet in conjunction with chairmen of committees and commissions to discuss their progress through the past year and to make plans for the October annual meeting. The Council will also convene in regular session on Sunday, July 18.

I would encourage as many of these commission and committee chairmen to attend the meeting as possible. The Council is setting up this meeting with the chairmen on Saturday evening, July 17, in an effort to become more informed on the activities of the commissions which are so important to the association's policies and plans.

Jon Black M.D

# The Woman's Auxiliary

## REPORTS TO ISMA

We read so much of health legislation and bills pending for further legislation that it isn't too surprising to note the following item in thumbing through a magazine of "Woman's Interest": "for travelers abroad, Intermedic (777 Third Avenue, New York City) will provide a round-the-world, 75-city directory of well qualified English-speaking physicians. They guarantee 24-hour service for an annual $5 fee." A "health on the run" principle of preparedness.



Health education (bridging the gap between scientific advancement and public consumption) is the primary means through which the auxiliary assists the medical association in its program for the advancement of medicine and public health. If our county auxiliary programs provide top level education and discussion, we may better meet and help solve community health problems. We must keep in mind that we must educate ourselves before we can educate the community.

As physician's wives, we are eligible to receive excellent health education material from the AMA Woman's Auxiliary to study and pass on to organizations in our communities, thus establishing ourselves as liaison to the local medical association and assisting in meeting specific community needs.

The Community Service Committee's new set of posters offers an opportunity to disseminate more health information to the general public. Our auxiliaries are urged to promote interest in Medical Self-Help training. The recent tornado disaster in our state points up the community responsibility and the U.S. Public Health Mobilization Division has material available.

A splendid new film dramatizes how the AMA and physicians provide modern medical care and protection. A contrast of medicine today and a generation ago, it is excellent for community groups and TV audiences. So many really fine films, posters, pamphlets and other media are available through the AMA that it seems a bit ridiculous that in practically every other mailing, we find material on "doctoring" oneself by "paperback." Health is still the number one interest and with the approval of our local doctors, we, the auxiliary, may perform a needed service in our communities.

Ruth V. Dunstone

**LOMOTIL**—*Pharmacologic Activity.*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly on the intestinal musculature to inhibit excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Comparative studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

# LOMOTIL® tablets liquid

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

## slows propulsion · relieves distress · stops diarrhea



*Precautions:* Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

*Dosage:* For full therapeutic effect – Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses*, until diarrhea is controlled, are:

**Children:**
3 to 6 months–3 mg. (½ tsp.* t.i.d.)
6 to 12 months–4 mg. (½ tsp. q.i.d.)
1 to 2 years–5 mg. (½ tsp. 5 times daily)
2 to 5 years–6 mg. (1 tsp. t.i.d.)
5 to 8 years–8 mg. (1 tsp. q.i.d.)
8 to 12 years–10 mg. (1 tsp. 5 times daily)

**Adults:** 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) **Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

# Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
*Indianapolis*

### Bereavement and Illnesses

A group of 44 widows were followed for a number of years in a study reported by Parkes.[1] Close medical studies were made on these women to determine whether there was an increased incidence of both psychic and somatic complaints after the death of their mates. There was a greatly increased incidence of psychiatric symptoms in the widows under 65 years of age, whereas this was not shown at all in the group over 65. The consultation rate for somatic complaints increased by nearly one-half in both age groups. The amount of sedatives prescribed to the widows was seven times as great during the 18 months immediately after their husband's death than it had been for the period preceding his death. Certainly none of these conclusions is startling; however, they confirm the fact that there is a close relationship between bereavement and both psychic and somatic illnesses.

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With a unique background of 80 years' experience, The Keeley Institute has earned an international reputation as a specialized hospital for the *restorative treatment* of the "problem drinker."

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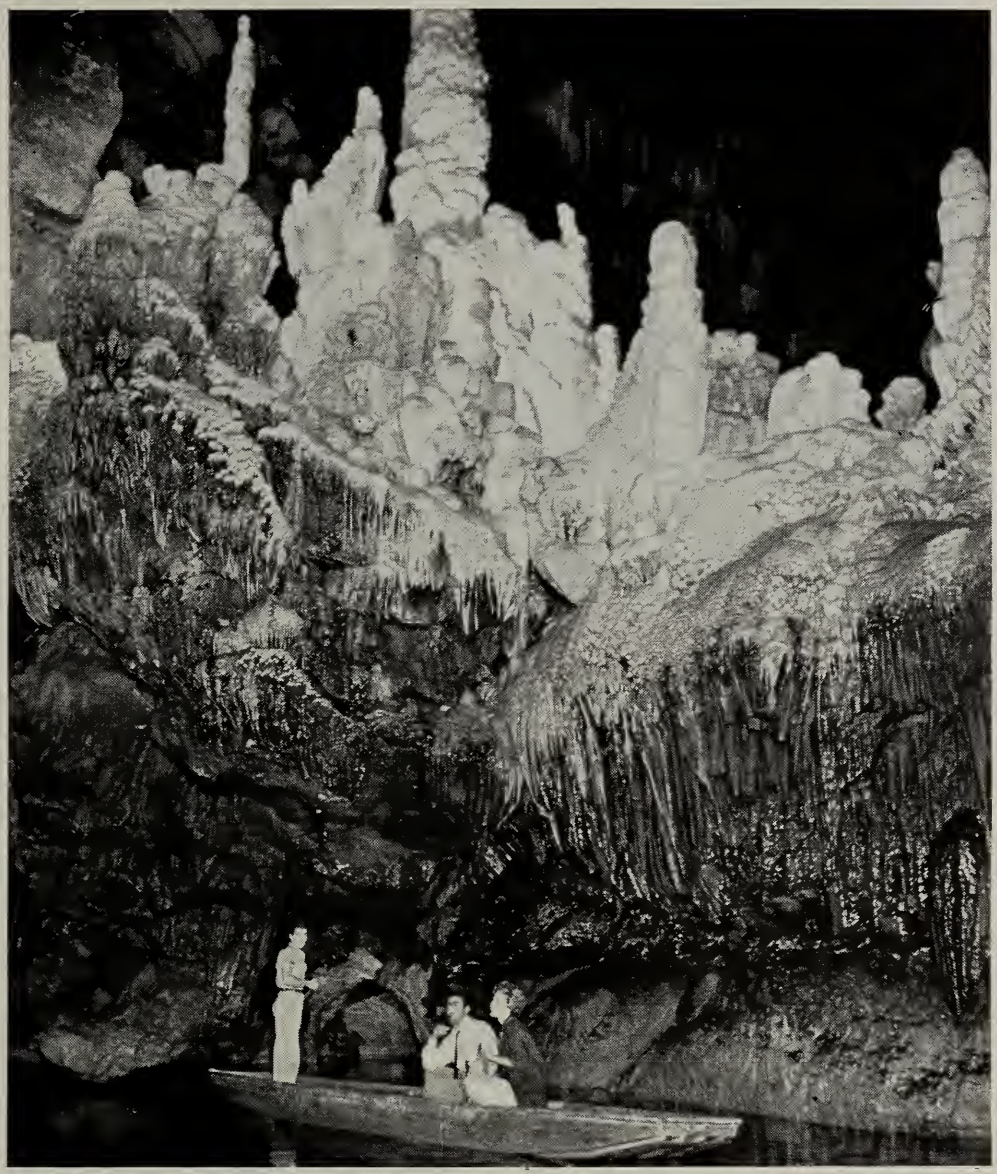
### Butazolidin and Rheumatic Fever

Butazolidin has not received much attention in this country in the therapy of acute rheumatic fever. The present study by Will and Murdoch[2] evaluates this drug in the treatment of 47 patients as compared with 41 cases treated with salicylates. Although this is a small series, the study seems to be well done and perhaps more evaluation of Butazolidin in the treating of the condition should be done. The authors report that clinical evaluation of the patients as well as laboratory studies showed that the patients improved more rapidly on Butazolidin than they did on aspirin. Even more striking was the fact that seven cases showed clinical recurrence after secession of salicylates while there were no cases that evidenced recurrence in the Butazolidin group. The authors also demonstrated that the hyperfibrinogenemia that is noted in rheumatic fever was corrected much more rapidly with Butazolidin than with salicylate therapy.

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2. Will, G., Murdoch, W. R.: Treatment of Rheumatic Fever: Comparison of Effects of Aspirin and Phenylbutazone, *Brit. Med. J.* 5404:281-284.

◄



# one place your hay-fever patient doesn't need **ORNADE**® (unless he has a cold)

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Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate), 50 mg. of phenylpropanolamine hydrochloride, and 2.5 mg. of isopropamide, as the iodide.

...but if your patient can't get away from hay fever, relieve sneezing, weeping and nasal congestion for 24 hours with one 'Ornade' Spansule® brand sustained release capsule q12h

*Summary of contraindications, cautions and side effects:* Do not use in patients with glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal obstruction, or bladder neck obstruction. Use with caution in the presence of hypertension, hyperthyroidism, or coronary artery disease. Drowsiness; excessive dryness of nose, throat or mouth; nervousness or insomnia may occur on rare occasions but are usually mild and transitory.

Before prescribing, see SK&F product Prescribing Information.

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# DAY BY DAY WITH THE F D A

**From the FDA Reports on Enforcement and Compliance.**

A new method of detecting bacteriological poisons in foods is now available to FDA district laboratories. The new procedure utilizes an antitoxin to detect and identify bacterial toxins of food poisoning. Culture of the food is not necessary. Testing time is reduced by almost half over older methods. Staphylococcal enterotoxins A and B may be positively identified.

* * *

Another "medical miracle device" has been lost to mankind. A quantity of Mathison Chevruel Crystal Pendulums have been confiscated together with books which described the use of the pendulum. It was described as a self-hypnotizer. The user, under hypnosis it was claimed, would be able to cure serious ailments, predict the sex of unborn babies, diagnose pregnancy within a minute of its onset and in addition determine whether food was potable or not by allowing the pendulum to swing over the dish. Claims were made for the observation by the user of his own subconscious mind, but apparently the inventor was not able to predict the fate of the device when it came in contact with the FDA.

* * *


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- Diabetes — *soft leather shoes*
- Bunions, spurs, corns, callouses — *metatarsal lifts and padding*
- Pigeon-toe, bow-legs — *orthopedic shoes, sole and heel wedges*

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A New York drug firm and its manager were recently fined $10,000 and $1,000 respectively for "callous indifference to regulations." Previously enjoined, the defendants were found to have shipped drugs without proper labels and without directions for use. They had also shipped new drugs without approval by the FDA and had dealt with unauthorized customers. The owner and president of the firm was not available, having been a fugitive from justice while living in South America since 1958. He was reported to have supervised the firm by mail.

* * *

The loss of food due to contamination and spoilage is tremendous. In 1964 over 26,000 tons of food were voluntarily destroyed or diverted to livestock feed. In addition over 250 tons of foodstuffs were seized by FDA. Much of the spoilage or contamination occurs after the food leaves the processing or packing plant and is preventable. The FDA has issued a leaflet which outlines rules for the proper storage and preservation of good. National food and warehousing trade associations are distributing copies. Most of the rules are based on cleanliness and frequent inspection.

* * *

Food poisoning as a result of bacterial contamination is more likely today than in the past due to the fact that the preparation of food is being shifted from the home to the factory. Precooked foods not subject to cooking by the consumer and mildly processed products stored for long periods at temperatures above freezing increase the chance of contamination. The National Academy of Sciences recommends good manufacturing controls. FDA inspectors are alerted to the necessity of requiring meticulous manufacturing standards. ◄

## to help relieve pain in common anorectal disorders

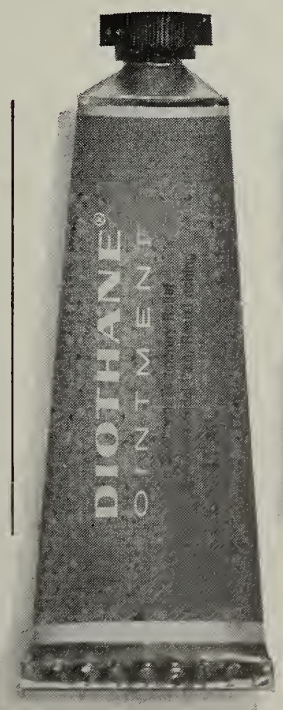
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COMPOSITION:
diperodon 1.0%; oxyquinoline benzoate 0.1% in a special ointment base.

INDICATIONS:
Provides temporary palliation of pain that may result from hemorrhoidectomy and from common anorectal disorders such as hemorrhoids, anal fissures, pruritus ani.






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# Medicine At Law

## DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

*Patient's Condition Made Elective Surgery Improper Regardless of Lack of Informed Consent* — A judgment for $443,124 was awarded to a patient who suffered total permanent disability as a result of a cardiac arrest while undergoing elective surgery at a Public Health Service Hospital. The patient, a young man, had suffered severe injuries as the result of a fall of 112 feet. Among the injuries was a fractured hip.

While undergoing surgery to restore the hip, the patient suffered a cardiac arrest. Circulation was restored, but he was left in a permanently "vegetal" condition. A federal trial court found that negligence in the performance of the surgery, in the choice and administration of the anesthetic or in the resuscitation of the patient after the cardiac arrest was not established. The court, however, did find that the evidence did establish that the patient was critically ill and that, in view of his condition, it was a departure from the required standard of medical care to proceed with such elective surgery at that time.

The court also found that the surgery was performed without informed consent. A written consent was ineffective, since it related to an entirely different surgical procedure. The court said that the patient had been verbally informed of the nature of the operation, but had not been informed of the risk to his life that was involved. The court, however, did not base its award on the lack of informed consent. It expressly said that it need not decide the legal consequences of lack of informed consent, since negligence in proceeding with the surgery had been established.

The damage award was allocated as follows: Past medical and hospital expenses —$26,000. Future medical and hospital expenses—$66,366. Future wage loss—$100,758. Permanent disability and conscious pain and suffering—$250,000.

*Vaughn v. U.S.*, Docket No. 6021 (D.C., W.D., Wash., Feb. 2, 1965).

*Doctor Is Railroad's Agent When Treating Its Employee*—In a suit against a railroad, under the Federal Employers Liability Act, for damages for the death of a dining car waiter from pneumonia while on his run, a trial court committed reversible error in leaving to the jury the determination of the question of whether a doctor, who diagnosed the patient's condition as bronchitis and administered penicillin, was an agent of the railroad, where the doctor was, as a matter of law, the railroad's agent, a California intermediate appellate court ruled.

The doctor had a contract with the hospital association of the railroad's employees and was paid a salary for services rendered. He was also called from time to time to perform emergency services for passengers or railroad employees. The railroad furnished no support to the hospital association.

The doctor spent only a few minutes with the waiter, and did not take his temperature or ask anyone for information about his condition. He advised the waiter to get off the train and enter the hospital, but said that it would be safe for him to remain on the train back to his home terminal where he could be treated by his own doctor. The waiter died several hours later before reaching his home terminal. The doctor ad-

mitted he would have diagnosed the waiter's condition as much more serious than bronchitis if he had known he had been sick and unable to work for several days of his run.

A doctor is ordinarily, by reason of his profession, an independent contractor, but he may under certain circumstances become an agent, the court said. While he was treating the waiter, the doctor was an agent of the railroad, within the meaning of the Federal Employers' Liability Act, because he was engaged in an operational activity of the railroad, because it could not operate properly without a full healthy crew aboard the train. He was also an agent, within the meaning of the Act, because a financial benefit accrued to the railroad from his services, since it was required by custom and practice to take care of an employee who was sick while on duty.

*Mangrum v. Union Pacific Railroad Company*, 41 Cal. Rptr. 536 (Cal., Dec. 1, 1964).

*Hospital Liable for Discharging Patient After Initiating Treatment*—An 11-year-old patient was entitled to recover damages in a suit against a private hospital for injuries sustained when the hospital, after admitting him for the performance of an appendectomy, required him to leave two hours later because his mother could not produce $200 cash at that time, a Florida intermediate appellate court ruled.

When the child arrived at the hospital, he was taken to the examining room, undressed, examined, and given medication. The hospital scheduled him for an appendectomy. When the mother failed to produce the cash, she and the child were required to leave the hospital, although the child was violently ill at the time. They went to another hospital, where the operation was performed several hours later.

Although a private hospital may reject for any reason, or no reason at all, any applicant for its services, this rule did not apply to the present case, the court said. Even though the proper forms had not been filled out, the hospital had, by initiating care of the child, admitted him. Once a hospital accepts a patient, it must continue to treat him if it is forseeable that his condition will be aggravated or the danger to him increased by removal. It was obvious that the child was injured by being required


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to endure pain and suffering longer than would have been necessary if the hospital had not wrongfully discharged him, the court said.

The jury's award of punitive damages to the child's mother must be reversed since it was not supported by an award of compensatory damages, the court said.

*Le Jeune Road Hospital, Inc. v. Watson*, 171 So.2d 202 (Fla., Jan. 26, 1965; rehearing denied, Feb. 19, 1965).

*Doctor Liable for Publication of False Medical Report Because of Refusal to Correct it*—A 13-year-old patient was entitled to recover $2,000 compensatory and $5,000 punitive damages in a libel suit against a doctor who had filed a medical report with school authorities which falsely stated that she was pregnant, where the doctor failed to correct the report after being informed of its falsity, the New Mexico Supreme Court ruled.

The patient consulted the doctor about a foot infection and he diagnosed her condition as athlete's foot. Her foot became worse and her parents, because of their concern over her continued absence from school, requested a home teacher. In accordance with established procedure, their request was sent to the special education department, which sent a form to the doctor on which he was to report his diagnosis and treatment of the child's ailment.

When the patient's mother asked the school principal about the delay in furnishing a home teacher, he told her that the doctor's report had stated the student was pregnant. The doctor refused the parents' repeated requests that he correct the report.

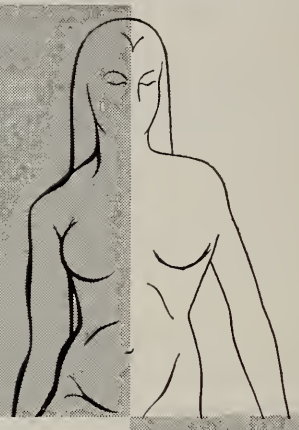
The report that the patient was pregnant was libelous *per se*, but it was made under a qualified privilege. The doctor's defense of qualified privilege could be destroyed only by proof of actual malice on his part. The doctor, after being informed of the report's falsity, had the affirmative duty to correct it, and his refusal to do so was sufficient evidence to support a finding that actual malice was present which removed the qualified privilege, the court said.

*Vigil v. Rice*, 397 P.2d 719 (N.M., Dec. 21, 1964).


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*Blood Bank not Liable in Serum Hepatitis Case*—A patient who contracted serum hepatitis after receiving several blood transfusions was not entitled to recover damages in a suit against the blood bank which furnished the blood, since the furnishing of the blood was more of a service than a sale and there is no way in which the presence in the blood of hepatitis virus can be detected, the Minnesota Supreme Court ruled.

All of the serum hepatitis blood transfusion cases in which recovery has been sought on a theory of negligence have been unsuccessful. No recovery is allowed under the theory of negligence because medical science, despite all due care, cannot detect hepatitis in the blood, and the determination of whether the benefits outweigh the risk is a matter of medical judgment in the particular case.

The patient contended that the furnishing of the blood was a sale to which an implied warranty that it was reasonably fit for the purpose intended attached, and that she was entitled to recover damages for breach of that warranty. The furnishing of blood is more in the nature of a service than a sale and there is no implied warranty. The fact that this suit was against a blood bank, rather than against a hospital, was immaterial, the court said. There was no reason for treating the blood bank, a nonprofit corporation, differently than a hospital, or for characterizing it as a commercial enterprise offering its products for sale in the market place in competition with others for the sole motive of making a profit. Although it favored the extension of the doctrine of implied warranty in commercial transactions from which both parties may profit, in order to promote high standards in business, it would not be appropriate to extend the doctrine to a voluntary and charitable activity, such as the blood bank, which serves a humane and public health purpose, the court said.

*Balkowitsch v. Minneapolis War Memorial Blood Bank, Inc.*, 132 N.W. 2d 805 (Minn., Jan. 22, 1965). ◄

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All 85 Blue Shield plans in the United States, Canada, Puerto Rico, and Jamaica are operated on a not-for-profit basis, a requirement for membership in the National Association of Blue Shield Plans, coordinator of all plans bearing the Blue Shield name. Their existance is predicated on the need for easing the burden of unexpected medical-surgical expense for all.

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Donald M. Moore, 3213 Ward, Carswell AFB, Fort Worth, Texas 76127—*General Surgery*

Donald J. Vandertoll, 8211 Madison Ave., Munster, Ind.—*General Surgery*

Lynn B. Roberts, 1744 Meyers Place, Oklahoma City, Okla.—*General Surgery*

Mario Ludmer, 256 Highland Ave., Pittsburgh, Pa. 14229—*Neurosurgery*

Roger G. Vieth, 1807 Hillcrest Dr., Durham, N. C. —*Neurosurgery*

Ferdinand A. Rossmann, 550 University Ave., Toronto 2, Canada—*Neurosurgery*

Richard S. Howard, University Gardens, Apt. B-7, Charlottesville, Va.—*Urology*

Charles W. Cullison, 705 State St., Lawrenceville, Ill.—*Industrial, Institutional, Insurance or College Health*

Manouchehr Malek, San Diego Co. General Hospital, San Diego, Calif.—*Emergency Service—House Physician*

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### GENERAL PRACTICE

Carroll County—BURLINGTON—population 500, located in the central part of Indiana, 15 miles from Kokomo; 20 miles from Logansport where hospital facilities are available. Principal economies are farming and industry. For details contact Robert M. Davis, President, Burlington Community Club, Burlington.

Decatur County—GREENSBURG—population 6,600. Industrial and farming community located between Indianapolis and Cincinnati, Ohio. 90-bed hospital with new facilities. Need for two general practitioners. Contact William D. Gibson, Administrator, Decatur County Hospital, Greensburg.

Fountain County—VEEDERSBURG—population 2,500 with a large surrounding area. One physician in the town. Hospitals located at Crawfordsville, 20 miles away and at Danville, Ill., twenty miles to the west. Also hospital at Williamsport which is 16 miles away. Primary sources of income are from farming, steel castings foundry and brick factory. Olin-Mathieson plant nine miles west. Contact Mr. Vern French, Secretary, Lions Club, 117 E. Second St., Veedersburg.

Fulton County—FULTON—Population 500 with a large surrounding area. Located in a rich farming area 14 miles from Logansport and nine miles from Rochester where hospital facilities are available. Community willing to build an office. Community without the services of a physician since the death of Dr. Franklin Dielman who had practiced in the community for 60 years. Contact Mr. Richard Davidson, Box 68, Fulton, for details.

Gibson County—HAUBSTADT—located in the southwestern part of Indiana—population 900. Principal economies are farming, meat packing and some manufacturing. Located 16 miles from Evansville and 12 miles from Princeton where hospital facilities are available. Contact Mr. Al Tieken, Box 63, Haubstadt 75439, for details.

Howard County—KOKOMO—population 50,000. Two hospitals. Opening for general practitioner, internist or general surgeon with a three-man group operating out of a new 18 room clinic. Fully equipped laboratory, staffed by a registered medical technologist and assistant. Contact Mr. Robert E. Thompson, Business Manager, 401 East Reynolds Drive, Kokomo. Telephone 45-73254.

Henry County—MT. SUMMIT—population 500. Five miles from New Castle where hospital facilities are available. Mixed farming and industrial area. Several small communities within a radius of ten miles without a physician. Contact Mr. Tom Bowers or Mr. R. L. Beavers, Mt. Summit, for details.

Huntington County—HUNTINGTON—population 16,000. Office of the late Dr. F. B. Mitman who practiced in Huntington for 40 years available. Need for general practitioner. Hospital located in the town which is close to Fort Wayne. For details contact Mr. Stanley Matheny, Huntington or Mrs. F. B. Mitman, 1471 Oak St., Huntington.

La Grange County—SHIPSHEWANA—population 400 to 500 located in the lake region of northern Indiana. Nine miles from La Grange, 20 miles from Elkhart and Goshen where hospitals are located. Farming and industrial area. Fully equipped office available. Contact John Williams, M.D., Shipshewana, for details.

Lawrence County—MITCHELL—population 4,000. Located 10 miles from Bedford where hospital facilities are available. One physician located in the town. Office available. Sixty-five miles from Louisville, Kentucky. Contact Mr. Raymond Morris, Mitchell, for details.

Marion County—ACTON—population 650, located 13 miles southeast of Indianapolis. Hospital located at Beech Grove which is 8 miles away. Contact Mr. Vierl G. Veal, 11333 Southeastern, Indianapolis.

Noble County—ALBION—population 1,500, located in northeastern Indiana; county seat of Noble County; 147 lakes in the county. The one physician in the community is very anxious for another general practitioner to locate there. Nearest hospital at Kendallville, which is 12 miles—Fort Wayne is 30 miles away. Contact Mr. Jerry Morr or David Van Meter, D.V.M., Albion.

Porter County—KOUTS—population 800, located in the northwestern part of Indiana. Principal economies are farming and steel industries. Porter County Hospital at Valparaiso is 12 miles from Kouts. Porter County is one of the most rapidly growing counties within the state. Contact Mr. H. P. Hudson, Chairman, Medical Improvement Committee, Kouts, for details.

Posey County—CYNTHIANA—population 600 located in the southwestern part of Indiana, 20 miles from Evansville where hospitals are available. One elderly physician in the community. Contact Miss Helen M. Martin, Secretary, Cynthiana Improvement Association, Cynthiana.

Pulaski County—MEDARYVILLE—population 900. No physician in the community. Two new county hospitals close—one at Winamac and the other at Rensselaer. Citizens of Medaryville willing to cooperate with physician locating there. Contact Mr. M. R. Clarke, Clarke's Drug Store, Medaryville, for details.

Spencer—ST. MEINRAD—located 150 miles northwest of Evansville and 75 miles from Louisville, Kentucky. Tri-State Highway to be located close by. Population 800 with a large drawing area. Modern four-room office available. Hospitals located in Huntingburg 17 miles away and Tell City which is 19 miles. Community provides an excellent future for anyone desiring a rural general practice. Contact St. Meinrad Development Corporation, % Mr. Othmar Ringeman, St. Meinrad.

White County—MONON—population 1,500. Located close to Lafayette and Monticello where hospitals are located. One physician in the community since the death of Dr. Wayne Houser. Need for another general practitioner. Contact Mr. Thad Hanway, Monon, for details. ◄


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# ABSTRACTS

## BOOK REVIEWS

### HANDBOOK OF OBSTETRICS AND GYNECOLOGY

R. C. Benson, M.D., Lange Medical Publications, Los Altos, California, 1964, $5.00.

It is remarkable that so much readily available and authentic material is condensed into such a small volume. This book is not a textbook but truly a handbook (1 x 3¾ x 7 inches) and contains 656 pages of text with a number of pen-sketch illustrations and a few useful tables. No space is wasted; on the inside of the front cover is a table of blood chemistry, blood and urine values, and within the back cover is an obstetrical calendar. The text is divided into obstetrics and gynecology, in all 29 sections, and it is amply indexed. The type is necessarily small since so much material is condensed into such a small volume.

The author of this handbook is professor of obstetrics and gynecology at the University of Oregon and a recognized obstetrical authority. This book is a first edition but the publishers have already scheduled a second edition to appear in two years. Since it is not a textbook, it contains no references and historical comments are not included. The last two chapters are devoted to the modern concepts of psychosomatic problems in women, and medical genetics.

It is clearly written with short and concise sentences, and the material is well organized. While it is not a textbook or a work particularly of interest to the trained specialist, it is admirably suited to use by the student, houseofficer or general practitioner; and is highly recommended, but does not replace a standard textbook for the student. No one can find so much authentic and up to date material on these subjects for the same cost.

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South Bend

## Abstracts From Various Literature, Prepared by AMA

### COUMARIN-INDUCED HEMORRHAGE CAUSING INTESTINAL OBSTRUCTION

W. B. Goldfarb (8718 Hoover Ave., St. Louis).
*Ann. Surg.* 161:27 (Jan.), 1965.

A syndrome of partial mechanical intestinal obstruction, usually in the small bowel, has emerged in recent years in patients with hypoprothrombinemia secondary to long-term anticoagulant therapy. Eleven such instances occurring in nine patients are discussed. The diagnosis is based on the history of the gradual onset of the symptoms of intestinal obstruction in patients receiving anticoagulant drugs. Invariably the prothrombin time was prolonged. Other hemorrhagic manifestations such as cutaneous ecchymosis, hematuria, and gastrointestinal tract bleeding were also present in eight of the nine patients. Submucosal intestinal hematomas form the anatomic basis of the obstruction. There was no evidence of necrosis or strangulation in the resected segments of bowel in the patients in whom surgery was performed. The pathological and roentgenographic features are characteristic. Clinical and roentgenographic evidence indicate that this process is readily reversible and suggest that operative intervention is unnecessary and may, in fact, be harmful.

### SOME ASPECTS OF HYPOGLYCEMIA

A. Patrick (12 Windsor St., Dundee, Scotland).
*Lancet* 2:1230 (Dec. 5), 1964.

Spontaneous hypoglycemia is common in mild degrees, with mental confusion an occasional feature. The hypoglycemic attacks which occur in the course of treatment by insulin are at times sudden and violent. The disturbance in children called night terrors is usually attributed to disharmony or other unhappiness at home; but its general aspect, including its sudden onset and great emotion, suggests that it is a manifestation of hypoglycemia. It is particularly an affection of nervous children. Are "nervous" children in fact some of those who are prone to hypoglycemia? Some other ailments of nervous children are often listed along with night terrors, particularly nocturnal enuresis. Could night terrors or nocturnal enuresis be relieved and prevented by sugar?

### CONTACT DERMATITIS COMPLICATING TRACHEOSTOMY

E. Padnos et al. (5631 Madison St., Chicago).
*Amer. J. Dis. Child.* 109:90 (Jan.), 1965.

A case of croup in which contact dermatitis of the tracheal mucosa prevented removal of a tracheotomy tube for more than three months is presented. Empiric use of corticotropin permitted extubation before an aqueous 1:1,000 solution of benzalkonium chloride (Zephiran chloride), used for disinfecting the plastic catheter, was identified by a series of patch tests as the specific offending agent.

### SICKLE-CELL TRAIT IN BLOOD DONORS

M. Kaufman et al. (Blood Bank, Kings County Hosp. Center, Brooklyn, N. Y.)
*Amer. J. Med. Sci.* 249:56 (Jan.), 1965.

At a large municipal hospital, 300 blood donors were surveyed as to their type of hemoglobin, by starch block electrophoresis. The sickle-cell trait was found in 14 (4.7%). Thirteen pints of the sickle-cell trait blood were given to recipients with a variety of illnesses. No untoward effects occurred, which were clinically detectable. Two autopsies showed no evidence of intravascular sickling in any of the organs. It is concluded that

Continued



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# ABSTRACTS

Continued

sickle-cell trait blood transfusions are not harmful even in those recipients where conditions theoretically favorable to sickling (acidosis, hypoxia, and decreased viscosity) are present. Dilution of the red cells containing sickle hemoglobin with normal cells appears to be the safety factor. Two possible contraindications to the use of sickle trait blood are in exchange transfusions in infants and in sickle-cell crises.

## AN INDICATION FOR SURGERY IN ACUTE ULCERATIVE COLITIS

B. N. Brooke and P. Sampson (St. George's Hosp. Medical School, Hyde Park Corner, London).

*Lancet* 2:1272 (Dec. 12), 1964.

The authors describe a radiological sign in acute ulcerative colitis, which in their practice has proved an indication for operation in the acute case, reducing the mortality of the severe acute cases from 30% to 3% in a series of 62 treated by operation. When a straight x-ray of the abdomen reveals unusual islands (pseudopolyps) against the contrast of intestinal gas, ulceration has penetrated beyond the mucosa, and disintegration of the bowel wall has begun. Toxic dilatation, in the author's view, is a late sign; surgical treatment should take place before this.


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## GASTRIC FREEZING

S. L. Wangensteen (Columbia Presbyterian Medical Center, New York).

*Arch. Surg.* 90:286 (Feb.), 1965.

Gastric "freezing" was performed in 25 dogs for periods varying from one to two hours. Mucosal damage occurred uniformly even after one hour of "freezing." Deeper gastric wall damage involving the muscle layers occurred only in the dogs receiving two hours of "freezing." Although prolongation of the "freezing" period from one to two hours did not alter the gross appearance of the stomach, it did cause further reduction in gastric wall temperatures. The gross estimates of gastric wall freezing were not reliable, as judged by submucosal and serosal temperature measurements. Uniform true freezing of the entire gastric wall would appear to be dangerous.

## VINBLASTINE SULFATE TREATMENT OF MALIGNANT LYMPHOMAS

S. H. Mehta and H. G. Mather (Southmead Hosp., Bristol, England).

*Brit. J. Clin. Pract.* 18:721-728 (Dec.), 1964.

Nine patients with advanced malignant lymphomas were treated with vinblastine sulfate (VLB). Useful temporary remissions occurred in seven patients and prolonged benefit in one. Treatment was started in the hospital and continued in the out-patient clinic with no serious side-effects. VLB seems to be as useful as nitrogen mustards and is sometimes effective when resistance has occurred to these drugs.

## METHOD FOR ESTIMATING BLOOD SUGAR

I. D. B. Brennie (Guy's Hosp. Medical School, London), H. Keen, and A. Southon

*Lancet* 2:884 (Oct. 24), 1964.

A new one-minute enzyme test strip for blood sugar ("Dextrostix") was studied. The method was found to be easy to perform: differences between observers were found to be small and the readings were little affected by lighting conditions. Comparison between strip readings and autoanalyser readings showed that the strip method tended to over-estimate higher ones, but the method seems worthy of further clinical trial.

## MASSIVE HEPATIC NECROSIS ASSOCIATED WITH GENERAL ANESTHESIA

L. B. Perry and J. A. Jenicek

*Milit. Med.* 129:1148-1151 (Dec.), 1964.

From 1958 through 1962 there were 22,701 general anesthetics administered at the Walter Reed General Hospital. Ether was the anesthetic agent in 39.0% of the cases, halothane in 29.2%, cyclopropane in 5.6%, and sodium pentothal and nitrous oxide in 24.2%. There were no cases of massive hepatic necrosis due to any general anesthetic agent.

## SMALL BOWEL ULCERATION ASSOCIATED WITH ENTERIC-COATED POTASSIUM CHLORIDE & HYDROCHLOROTHIAZIDE

D. J. Buchan and C. S. Houston (University Hosp., Saskatoon, Sask.)

*Canad. Med. Assoc. J.* 92:176 (Jan. 23), 1965.

Three cases of intestinal obstruction due to solitary localized ulceration, inflammation, and stenosis of the small bowel are described. All three patients were treated with a pill containing hydrochlorothiazide and an enteric-coated center of potassium chloride. The occurrence of this lesion suggests that such a combination should not be prescribed.

## CHANGES IN CARDIOPULMONARY FUNCTIONS RELATED TO ABSTINENCE FROM SMOKING: STUDIES IN YOUNG CIGARETTE SMOKERS AT REST AND EXERCISE AT 3 AND 6 WEEKS OF ABSTINENCE

R. A. Krumholz, R. B. Chevalier, and J. C. Ross (317 Emerson Hall, 1100 W. Michigan St., Indianapolis).

*Ann. Intern. Med.* 62:197-207 (Feb.), 1965.

This study was carried out to further evaluate the pulmonary alterations in young smokers and to determine their reversibility after short periods of abstention from smoking. In 10 subjects, determinations of lung volumes, lung mechanics, pulmonary diffusing capacity ($D_L$), heart rate, and oxygen uptake were made at rest, and $D_L$, heart rate, $O^2$ uptake, and $O^2$ debt were also determined during and after exercise. All studies were made before smoking was discontinued, and then three weeks and six weeks after the subjects stopped smoking. The results give further evidence that alterations in lung function occur in early life of cigarette smokers and that some of the alterations are quickly reversible with abstinence from smoking. The exact mechanisms by which these alterations are produced are, as yet, not well understood.

## HEMORRHAGE AS SEQUEL TO GASTRIC SURGERY

E. D. Palmer (Brooke General Hosp., Fort Sam Houston, Tex.)

*Amer. J. Med. Sci.* 249:200 (Feb.), 1965.

Observations are reported on 126 adults in whom gastric surgery was performed specifically because of hemorrhage. In 122 the source was either duodenal or gastric ulcer, or both. The postoperative follow-up period averaged five years per patient. During this period 66 patients had at least one more hemorrhage. In one half of these, the bleeding source was a lesion other than stomal (anastomotic) ulcer. Thirty-four patients required a second gastric operation because of the bleeding.

## PLASTIC BUBBLE ISOLATES PATIENT ANYWHERE IN HOSPITAL

C. B. Beal (Stanford University School of Medicine, Palo Alto, Calif.)

*Mod. Hosp.* 104:83-85 (Jan.), 1965.

The "isolated" patient may need to be moved for intensive care, surgery, dialysis or x-ray. A flexible, disposable, mobile plastic room, a "bubble," as used in the clinical research center, Stanford University School of Medicine, would serve the purpose. The major components of the system include: (1) an electrically equipped hospital bed with a built-in commode; (2) a service unit with an air impeller, an ultraviolet irradiated air channel, and four filters—ensuring that all air entering the unit is sterilized; (3) the flexible plastic bag surrounding the unit has an inflated capacity of some 500 cubic feet; fully inflated, the bag extends four feet to one side of the bed to allow the patient some ambulation; several built-in sleeves with changeable gloves are provided and the bag is supported from above by pull-chains; (4) an opaque plastic section serves as an entry chamber and shower; (5) an overhead butterfly frame allows expanding and contracting the bag; (6) a "satellite" bubble allows transporting the patient; (7) a fail-safe ventilation system is provided by the slight positive pressure of the isolator. The system so far has been evaluated with patients not seriously ill, but the author is now ready to study the value of this unit in the care of very ill patients. ◄

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## *New Film Available to Aid Victims of Heart Attacks*

"Reprieve," a 16 mm color motion picture sponsored by the Public Health Service, U.S. Department of Health, Education and Welfare offers hope and encouragement for the million-plus American men and women who each year survive a heart attack.

In the 22-minute film, former President Dwight D. Eisenhower and other heart patients, including a farmer, a mechanic and banker—all from Salisbury, Maryland—tell how sensible living habits and adherence to doctors' orders have enabled them to return to active and useful living.

"As one who has had a heart attack, lived through it, and gone back to work afterwards, I am quite sure that the first thing a heart patient must remember is that he is doing himself no favor by going to bed and pretending to be an invalid," says General Eisenhower at the beginning of the film.

Dr. E. Cowles Andrus, past president of the American Heart Association, is the principal medical commentator in the film. He speaks of the importance of Coronary Care units for hospitals which enable physicians and nurses to do their job more effectively. These units provide the means for immediate recognition of unexpected cardiac emergencies and for prompt action.

Dr. Eugene H. Guthrie, Chief of the Division of Chronic Diseases of the Public Health Service, introduces the film and describes the mission of the Public Health Service in helping to reduce the toll of death and disability from heart attacks.

For showing to groups, prints of the film, "Reprieve," can be obtained on loan free of charge by writing to the Public Health Service Audiovisual Facility, Atlanta, Georgia 30333.

## Dr. Bibler Attends Conference

Lester D. Bibler, M.D., attended a Curriculum conference on Family Practice at the University of Kentucky School of Medicine in Lexington, Kentucky in March.

## *"Reviews of Medical Motion Pictures" Publication Available from AMA*

A new publication, "Reviews of Medical Motion Pictures," is now available on request from the film library of the American Medical Association.

The publication contains reprints of all reviews of films published in *The Journal of the American Medical Association* during 1964.

"Reviews" is not a list of films approved or disapproved by the AMA. It offers a brief description and a frank, unbiased evaluation of motion pictures which are available to the medical profession. Copies of the review publication may be obtained from the Film Library, American Medical Association, 535 N. Dearborn St., Chicago 60610.

## Dr. Becker Elected

Dr. Harry G. Becker, Indianapolis surgeon and U.S. Army Reserve colonel, has been elected president of the state Reserve Officers Association. He succeeds Col. Harold W. Feichter, Fort Wayne.

## *"Planning for Mental Health" Booklet Is Now Available*

"Planning for Mental Health—A Report to the Nation" is a booklet which summarizes the Conference on Planning Comprehensive Community Mental Health Services.

The American Psychiatric Association conducted the conference and has published the 32-page booklet as a service to those who are interested in and are working in community activities for mental health. Copies of the booklet may be obtained by writing the Association at 1700 18th St., N. W., Washington, D. C. 20009.

## Dr. Svoboda Gives Lecture

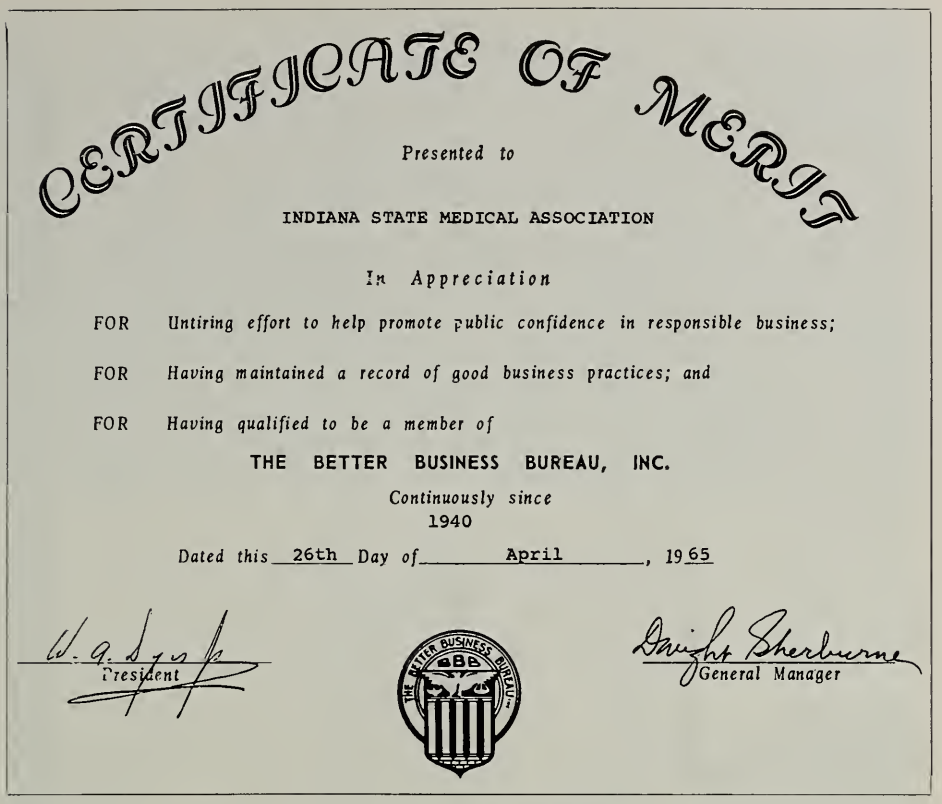
Dr. Gordon H. Svoboda, research associate of Eli Lilly and Company delivered the inaugural Rho Chi Lecture at Detroit on March 28 before the annual meeting of the American Pharmaceutical Association. His title was "Current Status of Research on the Alkaloids of Vinca Rosea and Their Role in Cancer Chemotherapy."

## *Research Investigators Asked To Submit Applications Now*

The Indiana Heart Association announces that applications from research investigators for support of studies to be conducted during the fiscal year beginning July 1, 1966, are now being accepted by the American Heart Association.

September 15, 1965 is the deadline for submitting applications for established investigatorships and advanced research fellowships.

Applications for grants-in-aid should be submitted by November 1, 1965. Grants-in-aid are



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FOR Having maintained a record of good business practices; and

FOR Having qualified to be a member of

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Dated this 26th Day of April, 1965

W. G. Sykes
President

Dwight Sherburne
General Manager

**THE Better Business Bureau presented this certificate of merit to the Indiana State Medical Association at an April meeting. Dr. Ralph Everly, chairman of the Executive Committee, accepted the certificate on behalf of the association.**

made to experienced investigators to help underwrite the costs of specified projects, such as equipment, technical assistance and supplies.

Further information and application forms for research awards may be obtained from the Director of Research, American Heart Association, 44 E. 23rd St., New York, N. Y. 10010; or the Indiana Heart Association, 615 N. Alabama St., Indianapolis.

## Dr. Glen V. Ryan Re-elected

Glen V. Ryan, M.D., Indianapolis, has been re-elected president of Indiana Blue Shield.

Other officers chosen were Mahlon F. Miller, M.D., Fort Wayne, elected vice-president and Lowell I. Thomas, M.D,. Indianapolis, elected secretary. H. Prentice Browning, president of the American Fletcher National Bank and Trust Company, Indianapolis, was re-elected treasurer.

## *"Current Concepts of Thyroid Disease" Book Published*

The second in the series of programmed instruction courses, published by Pfizer Laboratories, has just been published. Titled "Current Concepts of Thyroid Disease," the 93-page book presents a programmed review of diagnosis and treatment of thyroid disease. It is designed as a review course and was conceived not only as a review but also as a stimulus and foundation for more formal study by the reading of selected references.

The first of the series "Allergy and Hypersensitivity" has proven immensely popular and over 200,000 copies have now been distributed to physicians and medical schools. The pre-publication requests for the thyroid issue number more than 80,000.

## *Smith Kline & French Catalog Lists Free Services*

The "SK&F Catalog of Services" is published by Smith Kline & French Laboratories to list the wide range of services available from their organization without charge. The catalog may be obtained by writing SK&F at 1500 Spring Garden St., Philadelphia 19101.

Some of the important items in the catalog are clinically oriented postgraduate medical films and booklets on neurology, gynecology, resuscitation and psychiatry.

## *PMA Motion Picture Catalog Lists 184 Different Films*

A new catalog containing descriptions of 184 motion pictures suitable for lay viewing and pertaining to the health field has just been issued by the Pharmaceutical Manufacturers Association.

The films, which are available on a free loan basis to both lay and professional groups, cover such widely-discussed topics as accidents, alcoholism, allergies, artificial respiration, geriatrics, retirement, dental care, mental health, home safety, and career opportunities in the medical and allied professions.

On the more technical side, the films cover drug research, scientific agriculture, arthritis, open heart surgery, and the treatment of specific conditions of the digestive system, the heart, the lungs



**THE corridor outside the unique new surgery suite in the recently completed Hanley Addition to the James Whitcomb Riley Hospital for Children at the I.U. Medical Center is decorated with mosaic murals illustrating some of Riley's poems. Dedication ceremonies for the new surgery-radiology-rehabilitation wing were held in April.**

and the kidneys.

All of the films were produced by prescription drug firms, but do not promote products. All are 16mm sound. Running times range from ten to 60 minutes. The majority run about 30 minutes.

The catalog was prepared as a service to teachers, pharmacists, physicians, nurses, and others with leading roles in bettering public understanding of health matters. PMA urges such individuals to obtain copies for program chairmen of their civic, service, religious, and community organizations.

Copies of the catalog are available upon written request to the Director of Public Information, Pharmaceutical Manufacturers Association, 1155 Fifteenth St., N. W., Washington, D.C. 20005.

## Physicians Attend Meeting

Lester D. Bibler, M.D., Indianapolis and Lall G. Montgomery, M.D. of Muncie, Indiana attended the annual meeting of the U.S. Chamber of Commerce in Washington, D.C.

Dr. Montgomery is president-elect of the Muncie Chamber of Commerce and attended as a delegate. Dr. Bibler attended as a delegate of the American Medical Association.

## New AMA Secretary

Mr. Thomas E. Hanrahan has succeeded Dr. Raymond L. White as secretary to the American Medical Association's Council on Voluntary Health Agencies. He will also serve as assistant director of the AMA Department of Community Health and Health Education responsible for voluntary health organization.

Mr. Hanrahan, who has been a member of the AMA staff since 1959, will continue his activities as liaison representative from the AMA to the National Commission on Community Health Services until completion of this project in 1966.

## *Rehabilitation Institute Film Wins at American Film Festival*

"The Way Back," a documentary film about a disabled young girl's struggle to return to a normal life won the American Film Festival's blue ribbon first prize as the best medical documentary of 1965.

The 16 mm, 29-minute film was made at the Rehabilitation Institute of Chicago and was the first major effort of Robert Ford, a young writer-director, who worked in cooperation with Northwestern University's Department of Radio and Television.

Based on the true story of a 24-year-old coed who was seriously disabled by an automobile accident, the film sensitively portrays the physical and emotional obstacles she faced during her long months as a patient at the Rehabilitation Institute.

The American Film Festival, which is considered the "Academy Awards" of the 16 mm films, gave its coveted first prize to "The Way Back" in the



**RADIO station WFBM, Indianapolis, was a first place winner in the AMA medical journalism awards contest. The award of $1,000 and a plaque was given for a program entitled "Indianapolis Report: New Gyn Clinic Opens." Mr. Don Menke, (left) manager of WFBM stations, looks over the award. Looking on (left to right) are Bob Gamble, news manager, WFBM stations; Gene Slaymaker, WFBM radio news editor; Lester D. Bibler, M.D. (foreground) member of the Board of Trustees of the AMA; Joe M. Black, M.D., (behind Dr. Bibler) president of the Indiana State Medical Association; Irving Rosenbaum, M.D., who represented the Marion County Medical Society in the effort to establish birth control clinics and Albert M. Donato, M.D., president of the Marion County Society. Dr. Bibler made the presentation.**

all-inclusive category of "Health For General Audiences."

## *Dr. Anton J. Schwarz Named Dow Director of Research*

Dr. Anton J. Schwarz, head of the virus research department for the Pitman-Moore Division of The Dow Chemical Company, has been named Director of Research for Dow Human Health Products.

Dr. Schwarz was the developer of Pitman-Moore's new one-shot measles vaccine, Lirugen.

In his new position Dr. Schwarz will be responsible for research and development carried on by the various divisions of The Dow Chemical Company in the field of human health products. Dr. Schwarz will remain at Pitman-Moore's Research Center located near Indianapolis, Indiana, for an indefinite period.

## *ISMA Junior-Senior Day Receives National Publicity*

The ISMA Junior-Senior Day program has received favorable mention and national publicity because of a story in the May 31 issue of *AMA News*. The combined social get-together and informational session is described as "a practical addition to the education of many a medical student in Indiana."

## Famous Author Dies

Dr. Russell LaFayette Cecil, co-author with Dr. Robert F. Loeb of the *Textbook of Medicine*, considered a standard all over the world (11 editions since 1927) died of a brain tumor in Manhattan at the age of 83 in early June.

Dr. Cecil developed the agglutination test and was a leader in the battle against arthritis. He created one of the first arthritis clinics in the United States and was among the first to treat the disease with gold salts.

## Dr. Land Elected

Dr. Francis L. Land, Fort Wayne, has been elected vice-president of the American Academy of General Practice.

Dr. Carroll Witten of Louisville was selected as president-elect. Dr. Amos Johnson, Garland, North Carolina, is presently president of the Academy.

## *First Gallstone Operation Memorialized at L. S. Ayres & Co.*

The first successful gallstone operation in the world has been memorialized by the placing of a bronze plaque on the south building of L. S. Ayres and Company's downtown store in Indianapolis. The site is the location of the apothecary shop in which Dr. John Stough Bobbs performed the first cholecystotomy in 1867.

The plaque was presented by Mr. Julian Bobbs of Indianapolis, a direct descendant of Dr. Bobbs. Mr. Bobbs, Mr. James A. Gloin, president of L. S. Ayres and Dr. James Gosman, president of the Marion County Medical Society supervised the installation of the marker.

## *New AMA Occupational Health Guide for Physicians Published*

"Personal Protective Equipment for Employees in Industry" is a newly published guide which describes the need, selection and use of clothing and devices to protect workers from hazards which may result in occupational illness or injury.

Copies may be obtained without charge from the AMA Department of Occupational Health, 535 N. Dearborn St., Chicago 60610.

## Dr. Beeler Elected

Dr. John Beeler, Indianapolis, has been elected vice-chairman of the Council of the American College of Radiology. ◄

# Art, Hobby Show Planned For ISMA Indianapolis Meeting

Space will be provided at the 1965 annual meeting of the Indiana State Medical Association, Oct. 12-14 at Indianapolis, for a Physicians Art and Hobby Show.

Members of ISMA interested in exhibiting pieces and requiring any information regarding this can contact any one of the following:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington

Dr. Charles P. Schneider
2211 W. Franklin St.
Evansville 12

Dr. Truman E. Caylor
303 S. Main St.
Bluffton

Dr. Frank H. Coble
51 S. Eighth Street
Richmond

Dr. Lall G. Montgomery
Ball Memorial Hospital
Muncie

ISMA Headquarters
3935 N. Meridian
Indianapolis 8

It will be the responsibility of each physician to see that his work gets to the exhibition at the Murat Temple. Final arrangements will be taken care of by Dr. Holland and his committee.

The ISMA will provide suitable display facilities, but each physician is responsible for transportation costs and any other such expense involved in entering his exhibit.

---

## Application for Space in Art and Hobby Show Exhibit

Mail to:

Dr. Philip T. Holland
108 W. 7th Street
Bloomington, Indiana

Name_____

Address_____ City_____

Type and number of pieces to be displayed: Photography_____

Sculpture_____

Crafts_____

Painting_____

Other_____

Estimated amount of space required—lineal or square feet_____

Other information_____

_____

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—May, 1965

| Disease | May 1965 | Apr. 1965 | Mar. 1965 | May 1964 | May 1963 |
|---|---|---|---|---|---|
| Animal Bites | 1179 | 738 | 608 | 1068 | 1029 |
| Chickenpox | 312 | 324 | 681 | 483 | 758 |
| Conjunctivitis | 126 | 70 | 155 | 142 | 77 |
| Diphtheria | 0 | 0 | 1 | 0 | 0 |
| Dysentery, Unspecified | 158 | 34 | 155 | 45 | 111 |
| Gonorrhea | 438 | 322 | 299 | 325 | 233 |
| Impetigo | 118 | 48 | 130 | 69 | 75 |
| Infectious Hepatitis | 56 | 32 | 57 | 35 | 81 |
| Infectious Mononucleosis | 64 | 42 | 94 | 62 | 31 |
| Influenza | 278 | 652 | 5945 | 202 | 240 |
| Measles (Rubeola-Rubella) | 705 | 523 | 755 | 5019 | 1556 |
| Meningitis, Meningococcal | 5 | 6 | 10 | 2 | 3 |
| Meningitis, Other | 8 | 7 | 11 | 7 | 12 |
| Mumps | 285 | 208 | 413 | 751 | 519 |
| Pertussis | 6 | 13 | 7 | 41 | 29 |
| Pneumonia | 133 | 199 | 756 | 200 | 154 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 1 |
| Streptococcal Infection | 463 | 458 | 817 | 468 | 565 |
| Syphilis | | | | | |
| Primary & Secondary | 5 | 6 | 2 | 1 | 6 |
| All Other Syphilis | 103 | 114 | 94 | 98 | 111 |
| Tinea Capitis | 5 | 5 | 20 | 14 | 8 |
| Tuberculosis (Active) | 83 | 92 | 134 | 101 | 193 |

## From *The Journal* 50 Years Ago

. . . The wave of enthusiasm so prevalent a year or two ago concerning the curative effect of radium on malignant growths has gradually restricted itself to a consideration now of the limitations of this agent, the sequences and accidents following its use and the comparative results between Roentgen-ray and radium therapy. The last-named phase of the question has received renewed discussion, both because of the higher development of Roentgen-ray technic and because also such unfortunate effects as perforation of the hollow viscera are being reported in greater number as radium becomes more extensively used.

Clark, in reviewing the subject of cancer of the uterus, describes the work of Dessauer, an electrical engineer, who claims that it is technically possible to produce with the Roentgen-ray tube rays which have the efficiency of at least the softer gamma radiations of the radio-active substances, these rays possessing from 10 to 15 times more penetrating power than the ordinary so-called "hard" rays in general use. With these ultra-penetrating rays, Dessauer claimed to be able to direct radiations equal in value to several grams of radium, an amount greater than at present is ever available for therapeusis and which by suitable filters puts at one's disposal an artificial radium preparation of gigantic potency. These results, however, are those of an expert electrical engineer with the highest type of Roentgen-ray apparatus made, and do not represent the ordinary equipment of a hospital or practitioner. . . . Ben. Perley Weaver, M.D., "Treatment of Inoperable Malignant Disease" *JISMA*, July, 1915.

# FUTURE MEETINGS, SEMINARS, COURSES

## *American Ob-Gyn College Lists District Meetings*

The American College of Obstetricians and Gynecologists has announced its schedule of district meetings for 1965.

District V, to which Indiana belongs, will hold its district meeting at the Statler-Hilton in Cleveland on October 28 to 31. A concurrent meeting, the Conference for Obstetric-Gynecologic and Neonatal Nursing will be held at the same time in the Hotel Cleveland in Cleveland, Ohio.

## Canadian-American Medical Dental Ski Group Plans Meeting

The Canadian-American Medical Dental Ski Association will hold its sixth annual meeting February 6-13, 1966 at the lodge at Vail, Colorado.

Further information may be obtained from Dr. T. J. Trapasso, 816 Ashmun St., Sault Ste. Marie, Mich., secretary-treasurer of the organization. Travel and reservations information may be obtained from Group and Travel, Inc., 131 E. Allegan St., Lansing, Mich.

## *Basic and Advanced Courses In Psychiatry Offered Physicians*

To meet the growing need for further training and experience in the areas of psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists, basic and advanced courses will again be offered by the Department of Psychiatry and Neurology of the Chicago Medical School.

The aim of the postgraduate program is to increase the skills of the physician in the diagnosis and treatment of his general patient case load and in the management of the psychiatric problems which require limited goal therapy.

Courses will be offered beginning October 13. There is a limited enrollment, and advance registration is required. Address communications to: Bernard Block, M.D., Director—Continuing Education, Department of Psychiatry and Neurology, The Chicago Medical School at Mount Sinai Hospital, 2755 W. 15th St., Chicago, Illinois 60608.

## International Congress on Chest Diseases Scheduled

The Ninth International Congress on Diseases of the Chest, sponsored by the American College of Chest Physicians, will be held in Copenhagen from August 20 to 25, 1966.

The scientific program will include formal papers, symposia and motion pictures on recent developments, both medical and surgical, in cardiovascular and pulmonary diseases. There will also be Fireside Conferences similar to those sponsored by the College at various medical meetings in the U.S. Information may be obtained by writing Murray Kornfeld, 112 E. Chestnut St., Chicago 60611.

## *Wisconsin Pathologists Set Annual Meeting for November*

The Annual Meeting of the Wisconsin Society of Pathologists will be held in Milwaukee on November 13, 14, and 15.

Seminar slide sets are available on a first-come, first-served basis at $10.00 per set. Address inquiries to Dr. David J. LaFond, 561 N. 15th St., Milwaukee 53233.

## 16th National Conference On Disaster Medical Care

The 16th National Conference on Disaster Medical Care will be held at the Drake Hotel in Chicago on October 30 and 31.

Four symposiums—Care of the Traumatized Patient, Disaster Communications, Disaster Planning in Industry and Disaster Medical Resources, together with three papers on "Federal Agencies in Disaster" will form the main part of the program. Information may be obtained by writing the Council on National Security, 535 N. Dearborn St., Chicago 60610.

## *American Heart Association's Annual Scientific Sessions Set*

Six programs on clinical cardiology and simultaneous sessions on specialized cardiovascular subjects have been planned for the American Heart Association's 38th annual scientific sessions, to be held October 15-17 at the Hotel Americana, Bal Harbour, Florida.

The clinical sessions, consisting of panels, symposia, lectures and papers reporting clinical investigations, are designed as a postgraduate course in cardiology. They are of particular interest to the practicing physician.

Concurrent sessions devoted to the presentation of papers on original work in various cardiovascular subspecialties are of special interest to physicians and basic scientists working in these areas.

Registration forms, which include applications for hotel reservations, may be obtained from local Heart Associations or the AHA national office, 44 E. 23rd St., New York, N. Y. 10010.

## Laryngology, Bronchoesophagology Course Offered in Chicago

The Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in laryngology and bronchoesophagology

from September 20 to October 2.

This course is limited to 15 physicians, and will be under the direction of Paul H. Holinger, M.D. It will be held at the new Illinois Eye and Ear Infirmary, 1855 W. Taylor St. Instruction will be provided by means of animal demonstrations, and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures.

Interested registrants will please write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

## *Symposium on Suicide Scheduled for October 14*

The George Washington University School of Medicine will conduct a symposium on suicide—its nature, causes and prevention—on October 14 in the Lisner Auditorium in Washington, D.C. It will be one of the few major scientific meetings ever devoted exclusively to this national health problem.

The day-long program will explore the many facets of the subject, including suicide's cultural role, social causation, statistical importance, psychodynamics, treatment and prevention. The audience, invited from a wide geographic area, will include physicians and other individuals with a professional or scholarly concern with suicide.

Further information on the program will be available later.

## Deadline Set for Abstracts For World Diabetes Congress

The World Congress on Diabetes in the Tropics will meet in Bombay January 20 to 22, 1966. Abstracts of papers may be submitted for consideration of the program committee by mailing them to the Organizing Secretary, Dr. N. G. Talwalkar, Maneckji Wadia Bldg., Mahatma Gandhi Road, Bombay 1, India.

Time allotted to each paper including films and slides is limited to 10 minutes. Abstracts should be in the hands of the secretary prior to October 15.

## *Postgraduate Conference on Medical Aspects of Sports*

The Postgraduate Conference on the Medical Aspects of Sports will meet at the University of Rhode Island at Kingston, Rhode Island, on August 19 and 20.

Lectures, demonstrations and question and answer sessions will occupy the two-day program. Complete information may be obtained by writing H. M. Hofford, Director, Public Information Department, University of Rhode Island, Kingston, R. I.

## Nurses Will Discuss Cardiac Care At Miami Conference October 13-14

Registered nurses and members of allied health professions are invited to attend a national clinical conference on Nursing Care of the Cardiac Patient on Wednesday and Thursday, October 13-14 in Miami Beach. The meeting, co-sponsored by the American Heart Association's Nursing Committee and the American Nurses' Association Conference Group on Medical-Surgical Nursing, will be held at the Carillon Hotel.

A $10 registration fee will be charged for the conference, with registration forms available from the American Heart Association, 44 E. 23rd St., New York, N. Y. 10010. Registration at the nursing conference will also admit nurses to the scientific sessions of the American Heart Association, to be held October 15-17 at the Hotel Americana, Bal Harbour.

## *American College of Nutrition Sets Annual Scientific Meeting*

The annual scientific meeting of the American College of Nutrition will be held at the Americana Hotel in New York City on Sunday, October 10 at 10 a.m.

The topic will be "Nutrition—Alcohol—Office Practice." For further information, please contact Robert A. Peterman, M.D., F.A.C.N., Secretary, 3 Craig Court, Totowa Borough, New Jersey 07512.

## Flying Physicians Set Eleventh Annual Meeting

The eleventh annual meeting of the Flying Physicians Association will be held at the Deauville Hotel, Miami Beach, from August 22 through the 27th. The theme for the meeting will be the importance of safety as it relates to general aviation.

Membership is open to all licensed physicians who are members of medical societies approved by the board of directors. Physicians who are not actually pilots but who have a genuine interest in aviation may hold associate membership. Total membership now exceeds 1,700; 104 practicing physicians in Indiana are members.

Dr. Michael F. McGrath of Indianapolis and Dr. Robert M. Butterfield of Muncie are co-chairman of the Indiana state chapter. ◄

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# County, District News

## First District

Dr. Eugene W. Austin, Evansville, has been elected president of the First District Medical Society. Dr. R. E. Weitzel, Princeton, was elected secretary-treasurer and Dr. P. J. V. Corcoran, Evansville, re-elected councilor.

## Second District

Newly elected officers of the Second District Medical Society are: Drs. C. Philip Fox, Washington, president; J. S. Brown, Carlisle, re-elected secretary; Philip T. Holland, Bloomington, re-elected alternate councilor and Dr. Fox elected to the Blue Shield board. The 1966 meeting will be held in Washington.

## Third District

Newly elected president of the Third District Medical Society is Dr. Marion Hagan, French Lick. Dr. Elmer L. Wallace, New Albany, was elected alternate councilor and Dr. John M. Paris, New Albany, was re-elected to the Blue Shield board.

## Fourth District

New officers of the Fourth District Medical Society are: Drs. Merritt O. Alcorn, Madison, president; Ian S. Templeton, Seymour, vice-president; Francis W. Hare, Jr., Madison, secretary and Robert M. Reid, Columbus, councilor. Madison will be the site of the 1966 meeting.

## Fifth District

Dr. Robert M. Fell, Rosedale, is the new president of the Fifth District Medical Society. Assisting him will be: Dr. Milton Herzberg, Clinton, vice-president and Dr. J. W. Somerville, Clinton, secretary.

## Sixth District

New officers of the Sixth District Medical Society are: Drs. William E. Murray, New Castle, president; John J. Farrell, Jr., Greenfield, vice-president; Paul M. Inlow, Shelbyville, secretary-treasurer and Frank H. Green, Blue Shield board member. The 1966 meeting will be at Shelbyville.

## Seventh District

The Seventh District Medical Society has elected the following as new officers: Drs. William C. Stafford, Plainfield, president; Jay S. Reese, Martinsville, president-elect; James H. Gosman, Indianapolis, secretary-treasurer and Albert M. Donato, re-elected councilor.

## Eighth District

Dr. Lowell Painter, Winchester, is the new president of the Eighth District Medical Society. The new secretary-treasurer will be Dr. Paul Sparks, also of Winchester. The 1966 meeting has been set for June 1 at Muncie.

## Ninth District

Dr. Clarence G. Kern, Lebanon, has been elected alternate councilor of the Ninth District Medical Society. The 1966 meeting will be held in Benton County on May 19.

## Tenth District

Dr. Michael Shellhouse and Dr. E. J. Dierolf have been re-elected president and secretary, respectively, of the Tenth District Medical Society. Dr. Lowell H. Steen was also re-elected councilor of the district.

## Twelfth District

New officers of the Twelfth District Medical Society are: Drs. Warren L. Niccum, Columbia City, president; Frederic L. Schoen, Fort Wayne, vice-president; Kenneth F. Isenogle, Fort Wayne, secretary-treasurer and William R. Clark, Fort Wayne, re-elected alternate councilor. May 18, 1966 has been chosen as the date for next year's meeting.

## Thirteenth District

The date for the fall meeting of the Thirteenth District Medical Society has been changed to Sept. 29, 1965 at South Bend.

## Boone

Dr. Arnold Bachman, Indianapolis, spoke on the "Treatment of Eclampsia" at the May 4 meeting of the Boone County Medical Society. There were 21 doctors present.

## Clark

Field Secretary Robert Amick visited the May 18 meeting of the Clark County Medical Society to discuss coming meetings, the Washington situation and suggested action. There were 14 doctors present.

## Cass

Drs. Allan K. and Robert S. Harcourt, Indianapolis, discussed "Hand Surgery and Trauma" with the 38 members of the Cass County Medical Society present at the May 3 meeting.

## Elkhart

The Elkhart County Medical Society met May 6 to hear Dr. Harold Levine, Chief of Chest Medicine at Cook County Hospital, Chicago, speak on "Aesculapius through Cigarette Land."

## Floyd

"Maintenance of Life in Chronic Uremia" was the topic chosen by Dr. D. E. Gentile, Louisville, Ky., when he spoke before the May 14 meeting of the Floyd County Medical Society.

### Fort Wayne

Dr. George C. Manning, Jr., Fort Wayne, is the new president of the Fort Wayne Medical Society. Other officers are: Drs. Eugene F. Senseny, president-elect; James E. Shaw, secretary and Jerry L. Stucky, treasurer.

### Hamilton

Dr. Doyle Manhart, Sheridan, has been elected president of the Hamilton County Medical Society. Assisting him are: Drs. Clayton Thomas, Carmel, vice-president; Eunice Carter, Noblesville, secretary-treasurer; Joseph Lloyd, Noblesville, delegate and Adrian Lanning, Noblesville, alternate.

### LaPorte

"Diagnosis of Facial Injuries" was the topic of Dr. Edward Zucker when he spoke at the May 18 meeting of the LaPorte County Medical Society. There were 50 members present.

### Posey

President of the Posey County Medical Society for 1965-1966 will be Dr. Paul Boren, Poseyville. Other new officers are: Drs. Carroll Boyle, vice-president and Herman Hirsch, secretary-treasurer. Dr. L. John Vogel is delegate and Dr. John Crist, alternate.

### St. Joseph

Dr. R. W. Holdeman is the new president of the St. Joseph County Medical Society. Other new officers are: Drs. R. E. Nelson, president-elect and Josephine Murphy, secretary-treasurer.

### Shelby

Dr. Theodore Luros, Indianapolis, discussed "The Neurosurgical Approach to 'Stroke'" at the May 5 meeting of the Shelby County Medical Society. Sixteen members attended.

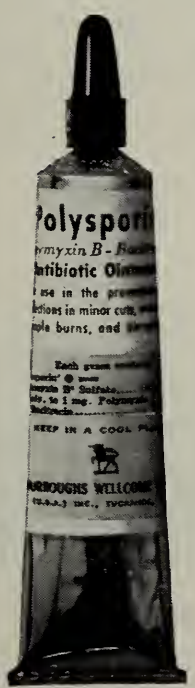
### Tippecanoe

New officers of the Tippecanoe County Medical Society are: Drs. Robert Bolin, president; G. M. Underwood, vice-president; P. W. Rothrock, secretary and H. S. Johnson, treasurer.

### Wayne-Union

Dr. Richard S. Ross, Associate Professor of Medicine at Johns Hopkins, discussed "Cineangiography and Radioisotope Studies of the Coronary Circulation in Man" at the May 11 meeting of the Wayne-Union County Medical Society. ◄


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**BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.**

# *Annual Meeting Dates of Professional Medical and Allied Organizations*

**AMERICAN MEDICAL ASSOCIATION CONVENTION**
Date Nov. 28—Dec. 1, 1965
Place Philadelphia, Pa.

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date May 3-5, 1966
Place Fort Wayne

**BONE AND JOINT CLUB**
Date October 13
Place The Athenaeum, Indianapolis

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

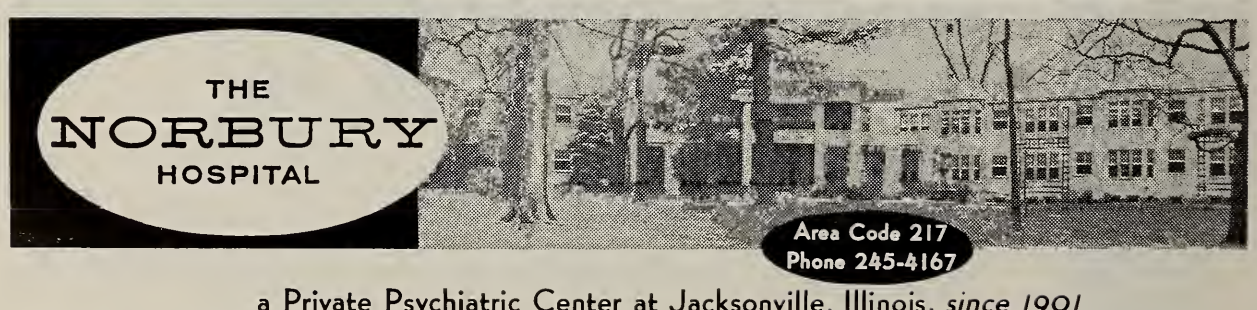
**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 12-14, 1965
Place Murat Temple, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 25-26, 1965
Place South Bend

**INDIANA ROENTGEN SOCIETY**
Date October 12, 1965
Place The Athenaeum, Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


a Private Psychiatric Center at Jacksonville, Illinois, *since 1901*

Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

*LICENSED:* Illinois Department of Mental Health.
*MEMBER:* Illinois Medical Service (Blue Cross-Blue Shield).

# Deaths

## Maxwell H. Dale, M.D.

Dr. Maxwell H. Dale, 64, Connersville physician, died June 6 at a hospital in Indianapolis.

A native of Fostoria, Ohio, Dr. Dale was graduated from Northwestern University and the Long Island College of Medicine. Following his internship at Bellevue Hospital in New York City, Dr. Dale practiced in New York for 15 years and taught surgery at Columbia University. He opened his practice in Connersville in 1946. He was a life fellow of the International Academy of Proctology, a diplomate of the American College of Surgeons and a member of the Fayette-Franklin County Medical Society.

## Carlton N. Fischer, M.D.

Dr. Carlton N. Fischer, LaPorte physician and surgeon for more than 20 years, died June 4 in a Chicago hospital. He was 51.

In addition to his private practice, Dr. Fischer served as physician for LaPorte High School athletic teams. Graduated from the University of Idaho and Rush Medical College, Dr. Fischer moved to LaPorte during World War II and was medical director of the Kingsbury Ordnance Plant. He was on the senior surgical staffs of Holy Family and Community Hospitals in LaPorte and was a member of the LaPorte County Medical Society.

## Wayne W. Houser, M.D.

Dr. Wayne W. Houser, 56, general practitioner at Monon for the last 28 years, died April 27 at his home.

A native of Hammond, Dr. Houser was graduated from the I.U. School of Medicine in 1933. He was a captain in the Army Medical Corps in World War II and was stationed in New Guinea and Australia; secretary of the White County Board of Health and formerly president of the White County Medical Society.

## Harry N. McClelland, M.D.

Dr. Harry N. McClelland, 49-year-old New Castle physician, died unexpectedly April 10 at his home.

Graduated from the I. U. School of Medicine in 1940, Dr. McClelland first went to New Castle in 1949. He practiced there for three years, went to Alexandria for 10 years and then returned to New Castle two years ago. He was New Castle city health officer; on the staffs of the Henry County and St. John's Hospitals and was a member of the Henry County Medical Society.

## Floyd B. Mitman, M.D.

Dr. Floyd B. Mitman, Huntington physician for many years, died March 24 after an extended illness. He was 68 years old.

Dr. Mitman was a native of Mulberry. He had practiced in Huntington since 1928 and prior to that was at Bippus for five years. He was graduated from the I. U. School of Medicine in 1922 and served his internship at City Hospital in Indianapolis. He was on the Huntington County Hospital staff and was a member of the Huntington County Medical Society.

## John W. Roll, M.D.

Dr. John W. Roll, vice-president of the medical staff at Community Hospital, and a Marion County deputy coroner, died May 8 at the age of 39.

Graduated from the I.U. School of Medicine in 1950, Dr. Roll served his internship at St. Vincent's Hospital and was a flight surgeon in the United States Air Force. He was on the staffs of Community, St. Vincent's and Methodist Hospitals and was a member of the Marion County Medical Society.

## Frank A. VanSandt, M.D.

Dr. Frank A. VanSandt, retired Bloomfield physician, died June 9 at the age of 88.

Graduated from Barnes Medical College in 1899, Dr. VanSandt had been a physician at Bloomfield more than 60 years and was a director of the Bloomfield State Bank from 1940 to 1961. He was a member of the Greene County Medical Society, a Senior Member and member of the ISMA 50-Year Club. ◄

# Association News

## EXECUTIVE COMMITTEE

May 15, 1965

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Kenneth O. Neumann, M.D., Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*; Robert Hollowell, attorney, and J. A. Waggener, executive secretary.

### Membership Report

| | |
|---|---|
| Number of members as of December 31, 1964 | 4,365 |
| 1965 members as of April 30, 1965 | 4,268* |
| Number of members as of April 30, 1964 | 4,259 |
| Gain over last year | 9 |
| Number of AMA members as of April 30, 1965 | 4,167 |
| Total 1964 AMA members as of April 30, 1964 | 4,146 |
| Gain over last year | 21 |
| 1965 AMA members: Dues paying | 3,668 |
| Exempt, but active | 499 |
| | 4,167 |
| Number who have paid state dues but not AMA dues as of April 30, 1965 | 101 |

*Includes 302 senior and three honorary members

### Headquarters Office

Upon motion of Drs. Neumann and Olvey, the secretary was authorized to purchase another IBM electric typewriter for the office.

By consent it was agreed to renew the subscription to the "Washington Report on the Medical Sciences."

For the information of the committee, the secretary reported on the mail survey for financial assistance, as requested by the Governor's Commission on Aging. No action was taken.

A service contract for service on the Addressograph and Multilith equipment was approved on motion of Drs. Larson and Olvey.

### Building Matters

The statement for the basement lighting was reviewed by the committee and was approved for payment upon acceptance of the work by Dr. Everly, on motion of Drs. Larson and Neumann.

### Treasurer's Office

The treasurer's report was approved by consent.

### Annual Convention, October 12, 13 and 14, 1965, Indianapolis

The contract for the music portion of the Gaslight Party was reviewed, and the secretary was authorized to sign this on behalf of the association, on motion of Drs. Larson and Rifner.

### Legislation:

*National*—A critical review was had of the current Medicare proposal before the Congress and the problems faced by organized medicine in attempting to prevent amendments to the bill in the Senate Finance Committee hearings.

### Organization Matters

The secretary reported on the Medical Registration Board's action in turning down an Illinois physician for endorsement in Indiana because of his licensure in Illinois by virtue of the National Board of examination.

The attorney discussed this thoroughly, and it was reported that the Commission on Medical Education and Licensure had a meeting with the Medical Board on May 4.

It was felt that the Medical Board is acting contrary to the law as passed in the 1961 legislature, and it was understood that the Commission on Medical Education is attempting to straighten this out promptly.

*Anti-poverty programs.* The question of professional representation on the anti-poverty programs was discussed and on motion of Drs. Larson and Rifner it was decided that the association should not seek professional representation on these committees.

The secretary reviewed for the information of the committee the report of actions taken by the AMA Board of Trustees at its meeting on April 2 and 3, 1965.

The secretary reviewed for the information of the committee the minutes of the meeting of the Blue Shield board held April 25, 1965.

A request for refund of dues paid the American Medical Association by the estate of Dr. Harry N. McClelland was reviewed and on motion of Drs. Neumann and Rifner, the association is to request the AMA to refund these AMA dues.

*Association of Professions.* The action taken by the Council on April 4 concerning the Association of Professions was reviewed and upon motion of Drs. Neumann and Rifner, this matter is to be referred to the Commission on Inter-Professional Relations with a request that the commission report back to the Executive Committee its opinions and recommendations.

Exchange of correspondence between the American Medical Association and the secretary of the Indiana State Board of Health concerning the make-up of the Hill-Burton Hospital Advisory Council was reviewed for the information of the committee.

Letter from Dr. Jack Hickman, addressed to the president, calling attention to the efforts of the state of Michigan to obtain interns through advertising in the *Journal of the Student AMA* was reviewed. This matter is to be placed on the agenda for the next meeting of the Executive Committee.

A letter from the Indiana Democratic State Central Committee soliciting advertising from the association for the forthcoming publication of the Democratic party was reviewed. Upon motion of Drs. Neumann and Rifner, the secretary is to advise the Democratic Central Committee that the association cannot legally support this endeavor but the request will be referred to a private group of physicians.

A letter from Dr. Joseph Weber, president of

the Indiana Roentgen Society, concerning a matter pertaining to radiological services was reviewed and the secretary was instructed to find out what happened at the April 14 meeting of the Indiana Roentgen Society concerning this question.

A letter from the American Cancer Society requesting the use of the name of the Indiana State Medical Association as a co-sponsor of the cancer symposium to be held at Indiana University Medical Center on September 15, 1965, was reviewed, and on motion of Drs. Rifner and Larson, the association will permit its name to be used as co-sponsor.

A letter from Dr. E. L. Hollenberg concerning policies on bleeding and coagulation time tests and a letter from the attorney on the subject were reviewed. Upon motion of Drs. Neumann and Rifner, this question is to be referred to the Indiana Association of Pathologists.

Letter from Dr. James H. Booze concerning emergency room problems and a letter from the attorney on this subject were reviewed and by consent, the Secretary was instructed to write Dr. Booze, pointing out several issues at stake in his question.

Resolutions from the Missouri State Medical Association, the Tennessee Medical Association, the Medical Society of North Carolina, the Arizona Medical Association and the Wisconsin Radiological Society were reviewed for the information of the committee, as was the action taken by the Ohio State Medical Association at its meeting on May 11.

## The Journal

A letter from the State Medical Journal Advertising Bureau, Inc., requesting information as to whether the association would sell a center spread without charging the preferred rate was reviewed and by consent it was taken that the association would turn down this offer.

A financial report of the State Journal Advertising Bureau was reviewed for the information of the committee.

The employment of a local sales representative to solicit advertising for *The Journal* was approved by consent.

## Future Meetings

*AMA meeting, New York, June* 20-25, 1965. Upon motion of Drs. Olvey and Larson, Mr. Bush was authorized to attend the annual meeting of the American Medical Association in New York.

The matter of favors to be distributed in the hospitality room and the report of the secretary on the availability of these from the Speedway Corporation were reviewed, and on motion of Drs. Larson and Rifner, the secretary was authorized to use his best judgment in obtaining favors and he was authorized to spend up to $500 for this purpose.

A notice of a meeting of the Committee on Osteopathy and Medicine of the American Medical Association, to be held in New York City on the morning of June 20, 1965, was reviewed and by consent it was agreed to ask Dr. Frank Green if he would represent the association at this meeting.

An invitation to send a representative to the Institute on Nursing Home Care of the American Medical Association, to be held in Columbus, Ohio, June 9 to 11, 1965, was turned down by consent.

There being no further business, the committee adjourned to meet again in the Indiana suite at the Americana Hotel, New York City, on Sunday, June 20, 1965, at 8:00 p.m., at which time the delegates and alternate delegates to the AMA are to be requested to meet with the committee. ◄

# THE COUNCIL

February 14, 1965

The Council convened at 10:00 a.m., February 14, 1965, in a special meeting called by the chairman, Dr. Eugene S. Rifner, with the following present:

**Councilors:**

First District—Not represented
Second District—E. T. Edwards, Vincennes
Third District—E. L. Wallace, New Albany, alternate
Fourth District—Robert M. Reid, Columbus
Fifth District—A. W. Cavins, Terre Haute, alternate
Sixth District—Not represented
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Whiting
Eleventh District—Eugene S. Rifner, Van Buren
Twelfth District—William R. Clark, Fort Wayne, alternate
Thirteenth District—Jene R. Bennett, South Bend

**Officers:**

Joe M. Black, Seymour, president
Kenneth O. Neumann, Lafayette, president-elect
Ottis N. Olvey, Indianapolis, treasurer

**Executive Committee:**

Ralph V. Everly, Indianapolis, chairman

**Guest:**

Harold C. Ochsner, Indianapolis, AMA delegate

**Staff:**

Ralph Hamill, attorney
James A. Waggener, executive secretary

Following discussion of the national health care program by Dr. Ochsner, AMA delegate, the officers and the councilors, Dr. Steen moved **"that the Council of the State Medical Association go on record as supporting the program of Eldercare, as outlined by the AMA, and, in addition, the Council moves that a program to augment this program, incorporating the following features, be enacted:**

**"(1) That we shall have some form of insurance for the elderly (over 65) in Indiana that will be underwritten by an insurance carrier, either**

commercial or voluntary non-profit plans, or groups;

"(2) That it shall cover all facets of medical care: hospitalization, nursing home, drugs, dental care and physicians' services currently encompassed in the Kerr-Mills law;

"(3) That this plan shall be contingent upon individual need as outlined by, as yet, an undetermined income level, and

"(4) That the fee schedule, or relative value schedule, be established by the Indiana State Medical Association to govern the recipients of these benefits, and that this fee schedule shall be established by representatives of the various specialties represented in the state medical association and in conjunction with the appropriate commission of the state medical association."

**Dr. Steen's motion was duly seconded.**

**Dr. Steen then asked that the following be included in his motion:**

"(5) That this be proposed to the legislature of the State of Indiana at its current session and an attempt be made to get this introduced."

**The second concurred in this addition to the original motion.**

**Dr. Edwards moved to amend item four to substitute "Usual and customary fees in Indiana" in place of "fee schedule, or relative value schedule." Motion seconded by Dr. Donato.** Discussed by Drs. Edwards, Steen, Neumann, Bennett, Petrich, Donato, Clark, and Judge Hamill.

**On roll call vote, the amendment was adopted, 9 to 5.**

**On roll call vote, Dr. Steen's amended motion was passed unanimously.**

Dr. Neumann's question of how this program is to be presented to the governor was discussed by several.

**Dr. Donato moved for adjournment,** saying that a positive program had been proposed, no more could be accomplished at this meeting, and amendments could be made in emergency meetings. **Motion seconded by Dr. Taylor. On roll call vote, the motion was lost, 8 to 7.**

Following discussion by many, including Judge Hamill, as to how this program could be written into a bill, specifically with reference to "usual and customary fees in Indiana," **on motion of Dr. Steen, duly seconded, the Council voted to reconsider the above resolution passed by the Council.**

**Dr. Steen moved "that the paragraph in the original motion that was to be submitted to the legislature relative to fees be removed from the motion and be stated as a matter of principle to be used in any future negotiation of a contract with the state government for the provision of these services." Motion duly seconded, put to vote, and motion to amend the original motion unanimously carried.**

The secretary read the original motion, with the amendments which had been adopted.

The secretary read the motions and amendments to the motion making the matter before the Council to read as follows:

**Dr. Steen moved that "the Council of the Indiana State Medical Association go on record as supporting the program on Eldercare as outlined by the American Medical Association and in addition the Council moves that a program to augment this program incorporating the following features be enacted:**

"(1) That we shall have some form of insurance for the elderly (over 65) in Indiana that will be underwritten by an insurance carrier, either commercial or voluntary non-profit plans or groups.

"(2) That it shall cover all facets of medical care: hospitalization, nursing home, drugs, dental care, all physician services as currently encompassed in the Indiana Kerr-Mills law, and that these services shall be on a free choice basis.

"(3) That this plan shall be contingent upon individual need as outlined by, as yet, an undetermined income level.

"(4) And that as a matter of principle, to be used in any future negotiations on a contract with state government for the provisions of these services to the needy elderly being based upon a fee schedule based on the usual and customary fees in the locality."

The consensus of the Council was that the amendment proposed by Dr. Edwards is the basis for negotiating contracts, but not a basis for the proposed bill.

**On roll call vote the motion to accept the resolution as amended and as above stated was adopted unanimously.**

There being no further business, by consent the meeting was adjourned. ◄

## THE COUNCIL

April 4, 1965

The Council of the Indiana State Medical Association convened for its spring meeting at 10:00 a.m., Sunday, April 4, 1965, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. Eugene S. Rifner, the chairman, presiding.

Roll call showed the following present:

Councilors:

First District—Not represented
Second District—E. T. Edwards, Vincennes
Philip T. Holland, Bloomington, alternate
Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—A. W. Cavins, Terre Haute, alternate
Sixth District—William R. Tindall, Shelbyville
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Paul W. Sparks, Winchester, alternate
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Whiting
Lee Trachtenberg, Hammond, alternate
Eleventh District—Eugene S. Rifner, Van Buren
Lowell J. Hillis, Logansport, alternate

Twelfth District—Milton F. Popp, Fort Wayne
Thirteenth District—Jene R. Bennett, South Bend

**Officers:**

Joe M. Black, Seymour, president
Kenneth O. Neumann, Lafayette, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer

**Journal:**

Frank B. Ramsey, Indianapolis, editor

**Executive Committee:**

Ralph V. Everly, Indianapolis, chairman
G. O. Larson, LaPorte, member

**Guests:**

Guy A. Owsley, Hartford City, AMA delegate
Jack E. Shields, Brownstown, AMA delegate
Harold C. Ochsner, Indianapolis, AMA delegate
James A. Gosman, Indianapolis, AMA alternate delegate
Robert M. Brown, Marion, AMA alternate delegate
Glenn W. Irwin, Jr., Indianapolis, dean, I.U. School of Medicine
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Student Loan Committee
Charles X. McCalla, Paoli, chairman, Commission on Inter-Professional Relations
Dwight W. Schuster, Indianapolis, chairman, Commission on Legislation
Eli Goodman, Charlestown, chairman, Commission on Special Activities
Robert H. Rang, Washington, member, Commission on Inter-Professional Relations

**Staff:**

Ralph Hamill, attorney
Howard Grindstaff, field secretary
Kenneth W. Bush, administrative assistant
J. A. Waggener, executive secretary

**Minutes of the meetings held January 24, 1965 and February 14, 1965 were approved by consent.**

## Reports of Councilors

DR. DONATO, Seventh District, reported that the Seventh District meeting, originally set for May 5, had been changed to May 19 due to a conflict. The meeting will be held at the Eldorado Country Club, south of Indianapolis.

DR. POPP, Twelfth District, reported that his district had become quite active recently, for several reasons. "Sabin oral vaccine is being given in Allen, Steuben and Whitley counties today (April 4), and it will be given again about June 6. The Jaycees and many civic groups are behind this campaign, it has been well publicized in the papers, and the image of the doctor in our district has been improved.

"We have some elections coming up. We are having a preliminary meeting on April 8 as sort of a prelude to our district meeting on May 19. The Twelfth District will elect an alternate councilor to replace Dr. William R. Clark whose term expires this year." Dr. Popp paid tribute to Dr. Clark, saying "He has many of the attributes that are important in an alternate councilor, he has been very faithful in attending Council meetings and he has done one whale of a job."

DR. BENNETT, Thirteenth District, reported that the exact date in September of the Thirteenth District meeting had not yet been set.

## Unfinished Business

1. *Transfer of fees for radiology and pathology services from Blue Cross to Blue Shield.* Judge Hamill reviewed briefly the previous actions on this matter. "You will recall we were instructed to prepare a legal brief. Then we were to endeavor to effect a settlement, and thirdly, in failing to do that, we would institute a lawsuit. The brief was completed to our satisfaction. We concluded that the position which we previously stated to you was correct, that clearly such things as radiology and pathology, and so forth, were professional services and had no business being performed by a hospital. We feel that this can be prevented either by well, perhaps lastly, criminal action, but more preferable, injunctive relief or declaratory judgment act. So it seems to me that we are down pretty much now to the question of what do we do. Do we remain as we are, or do we proceed?

"That's the status, I believe, at the present time, and we await your instructions."

This matter was discussed by Drs. Neumann and Kerr, and Judge Hamill. **On motion of Drs. Taylor and Steen, the Council authorized the attorneys for the state medical association to go ahead with this in any manner they see fit.**

## Reports of Officers

DR. JOE M. BLACK, president: Mr. Chairman, members of the Council: I will try to inform you of what has been going on since the last Council meeting. I want to thank the commissions through the Council for their efforts so far this year in legislation and also in public health—via Junior-Senior Day, which was a very excellent program last weekend.

I want to ask you to do some thinking about cooperation and liaison with various organizations in the state such as the Michigan plan on the Association of Professions. Dr. Bennett attended the Michigan meeting and will tell us about that later on today.

I also want to call to your attention the Farm Bureau's program in regard to reapportionment in Indiana. If you analyze this matter, in the 1967 legislature, nine counties will be controlling the State of Indiana—nine counties in the House and seven counties in the Senate will have absolute control of the State of Indiana. Now, I don't think this is particularly good for all the citizens of Indiana, and I think that medicine should be interested in this fact, be knowledgeable of this fact, and so inform your Congressmen and your Senators.

We have a problem with communications. We aren't getting the word about. I think that it should

be brought to the attention of the men in your county and dictrict societies that they'll be better informed physicians if they will look at their *Journal* and read it. Some very excellent scientific articles are published there, and I think it would be to their best interests to keep informed.

At this time I don't know whether all of you know, Dr. Irwin is here, our new dean. Glenn, would you stand up? I am sure we have a real fine friend and an excellent man in our new dean. He's knowledgeable about our problems and will be helpful to us in some of them. We are going to have a meeting of the Liaison Committee with I. U. School of Medicine in the near future and talk over some of our problems in medical education and in getting more physicians for Indiana. I think this is for the best interest of medicine in the state.

The time is coming when we as physicians are going to have to pay attention to what third parties think about our fee schedules. I think that Welfare and Kerr-Mills and all are going to start thinking about setting fees for us. I feel it is very important that you study your memo from the Executive Committee and that you go home and discuss it in your societies, and start thinking about this problem. No longer do I feel that we as a state organization can defend a man who charges excessive fees. I think he has a right to charge the fee he wants, but we can't defend a man who charges an excessive fee for the average income patient.

I have discussed the problem of more physicians in the state. Harrison Ullmann, through *The Indianapolis Star*, has been doing some research and writing in this area. He has contacted the dean, he has contacted me, and I am sure he will try to help us and not be too critical of us if we also will get our shoulder to the wheel. I think it is real important that anything we can do to improve the number of physicians in Indiana is a great asset.

May 12th is Alumni Day at the University. I wish all of you who are in the Alumni Association would attend. Dr. Appel, president-elect of the AMA, will be here. It is important that we have a good crowd. Also, as you know, Dr. Bibler is running for AMA trustee.

This is about the substance of my remarks for the day. I do wish that the Council would take a little time in the future and go over some of these problems that I have presented. Thank you.

*Reception.* Drs. Shields, Popp, Donato and Bennett discussed financing of the reception to be held in honor of Dr. James Z. Appel, president-elect of the AMA, following alumni day festivities. **On motion of Dr. Shields, duly seconded, the members of the Council voted to forego their traveling expenses to the April 4, 1965 Council meeting, which would amount to about $300.00, and to allocate this money to the fund.**

DR. KENNETH O. NEUMANN, president-elect: I have no additional report to what Joe has already made. I too have been enjoying some hospitality around the state, from some of the various societies.

I do have one request I would like to make of each of you. The time to make appointments for the various commissions is not due until next fall. However, there are a lot of vacancies, resignations, and so forth, appearing on some of these commissions and in the next month or so I am going to send to each of you a letter listing the vacancies that have occurred in your particular district, or will occur in October, and also indicating those who are no longer eligible for reappointment. Now we have a provision in the Constitution and Bylaws that limits the appointments of commission members to two consecutive terms of three years each. And we are going to stick to that. I think the time has come when we need to get new blood in some of these commissions. I have asked Miss Chapple to look this up and see who has served two consecutive terms. And then I would like for each of you to search your conscience and try to come up with some individuals from your district whom you think will participate actively on these commissions so that a little new blood can be pumped into a few of these commissions. Most of the commissions have been very active and have worked very well, but there are some that we are probably going to have to stimulate just a little bit. I think we ought to go by the Constitution which provides for this. There is provision for the appointment of a few at-large members—there's two on each commission—and we will try to pick up some of these from this group, so will you please get this information and make your recommendations back to us so we can get this organized early this summer, rather than next fall. Thank you.

DR. OTTIS N. OLVEY, treasurer: Mr. Chairman, guests: This report is as of March 31, 1965. At that time, the bank balances of cash on hand were:

| | |
|---|---|
| General Fund | $43,974.90 |
| Journal | 12,812.64 |
| Building Fund | 10,058.99 |
| Medical Defense Fund | 5,881.82 |
| Student Loan Fund | 2,512.24 |
| Kitchen Fund | 1,179.52 |
| Total cash, all funds | $76,420.11 |

In investments, and in the savings accounts we have $70,000.00. Of this $70,000.00, $50,000.00 is in a certificate of deposit and $20,000.00 is deposited in savings. Then we also have $60,000.00 in government bills, for a total of $130,000.00. Also, we have General Fund securities, the maturity value of which is $60,000.00. Adding these up we have total investments of $190,000.00, which, with cash on hand, gives us a total of $266,420.11.

I might also say that our building loan is down now to $39,000.00.

DR. FRANK B. RAMSEY, editor of *The Journal*: Dr. Olvey has explained to you about the finances of *The Journal.* We are in a good cash position so far this year. The advertising is increasing slowly. In 1963 we had 40 pages per issue, in 1964, 35; and for the first quarter of this

year we averaged 37 pages each issue.

I would like to make a short report on the readership survey. Actually, Dr. Black doesn't have the latest figures on this. Returns started in real slowly. Ordinarily any readership survey in a journal such as ours which binds the questionnaire in the journal has usually a return of one or two percent. Five percent is considered excellent, and as high as 10%, colossal. Our return right now is six percent, which, on the grounds of the way things run usually, is not bad at all. It only suffers by comparison with some of the other state journals. Several of them have had 30 and 35% returns, and the early overall average for the country was 15%. In spite of the fact that we have had less return of our questionnaire than a lot of the other journals, and except for the occasional caustic comment, which you all know must be expected, we have had a tremendous number of constructive, well thought-out comments and suggestions and a tremendous number of real well-worded compliments. There are so many things in regard to the comments that were written in on these questionnaires that it is going to take me some time to get them all written out and classified. I want to make a detailed report to the Editorial Board for later consideration.

I want to say to the dean, since he is here today—I was amazed at the number of requests that we have more papers from the medical school; this in spite of the fact that I've never turned down a paper from there, and I have often felt that I was out there too often asking for things to be written by the faculty and still a good proportion of the readers would like to have more things from the medical school. This is something that I need to talk to the dean about later.

Overall, the results of the readership questionnaire I think are going to be extremely helpful.

DR. GLENN W. IRWIN, JR., dean, Indiana University School of Medicine: Doctor Rifner and members of this Council: One month and four days ago my life was changed when I took the position of Dean and my work was obviously cut out for me. Today, I wish to express a few highlights of my feelings concerning medical education. Many of you already are quite familiar with these. First of all, just a few comments about some of our problems and our goals. In my opinion, there is no question we should have a major overhauling of the present curriculum. This is true not only of Indiana but of many schools. Our active curriculum committee has important data suggesting again that there must be changes. I am interested, of course, in a curriculum that is broader than our current program. Also, the student should have a closer contact with the faculty in all spheres of medicine. This is a very difficult goal to achieve in a large-enrollment school such as Indiana.

One of the other features that needs strengthening very much is the field of postgraduate or continuing medical education. There are many ways in which this goal can be reached including working actively with this Council.

Another area that I would like to mention is the faculty. I think this must be very critically reviewed. The newspapers have indicated we need additional faculty and I think this is true. I certainly will stress the fact that this addition should represent a well-balanced faculty. Granted we do need full-time faculty, primarily in the basic sciences, but also in the clinical areas. We also need in certain departments faculty members who are fundamentally in the practice of medicine to strengthen the clinical teaching. New and important ideas are required concerning proper exposure of all disciplines of medicine to students. Some progress is being made in this area but there is much to be done.

As far as bricks and mortar are concerned, actually I think we are beginning to solve the problem of hospital space. I always thought that one of the important buildings needed was a good teaching hospital, but it is also important that we have office and laboratory space particularly for full-time basic science men.

In conclusion, may I say that I hope you will call on me when problems in medical education occur. I pledge my support to this organization to help solve our problems and our goals through a close partnership between the School of Medicine and the State Association. Thank you.

DELEGATES TO THE AMA: Drs. Guy A. Owsley and Jack Shields, AMA delegates, and Dr. Neumann discussed the election of a president-elect of the AMA and the re-election of Dr. Lester Bibler to membership on the AMA Board of Trustees at the June meeting of the AMA in New York.

DR. LESTER D. BIBLER, AMA trustee, complimented Dr. Irwin on his statements on the new era in medical education in Indiana, and spoke of "the considerable concern about the encroachment or advance in the use of federal funds in medical education. This is getting to be a rather astronomical figure in view of the fact that private funds are being frozen or are difficult to come by any more. I think that we should be particularly interested in the future of medical education, especially if it is under too much government control."

Dr. Bibler mentioned some of the matters which had come to the attention of the AMA Board of Trustees as its recent meeting:

(1) World Medical Association meeting in London, September 19-24, 1965. He urged the members of the Council to attend that meeting. "There is some concern that actually the World Medical Association is being carried by the membership of the United States and the contributions of the AMA. Perhaps some participation by attending members in this meeting would help."

(2) Increased activity in the Student Loan Fund of the AMA. In 1963, 6,553 loans were granted, and in 1964, 7,415 loans were granted, an increase of 13% in the past year. The loans to residents increased from 24% to 28% of the total loans granted.

(3) Disability insurance carried by the AMA.

This is to be revised, possibly in the near future, and there is a possibility of an increase in premium rates and at the same time the requirements for participation will go up.

(4) Meeting of the nominating committee and vacancies on the various councils and committees of the AMA.

(5) Legislation pending in Congress.

HR-3727—Herlong-Curtis bill, recommended for approval.

SB-596—recommended that this be opposed.

HR-3699—recommended support of this Mills Bill.

SB-576—to provide partial cancellation for medical student loans. Recommended opposition.

(6) Plan to present 26 half-hour films in the next year with AMA background, bringing out various operations of medicine, particularly in medical service, medical care, medical education, quackery and other things of particular interest.

(7) Pamphlet regarding Medicare.

(8) Revision of Byrnes Bill.

## Matters Referred to Council by Executive Committee

DR. RALPH V. EVERLY, chairman, Executive Committee, presented the following matters:

1. *Memorandum from the Executive Committee concerning fees to be charged for medical care under those programs financed by the Federal government and other third parties.* Dr. Everly read the four page memorandum and this was discussed by the chairman and Drs. Holland and Kerr. **Dr. Edwards moved "that the Council prepare a suitable resolution for the House of Delegates stating as a policy that the physician shall receive the usual and customary fees as normally charged in his particular community when dealing with governmental payment programs." Motion seconded by Dr. Neumann,** discussed by Drs. Steen, Edwards and Holland, **put to vote, and carried.**

The chairman of the Council appointed Dr. Edwards to write this resolution. The resolution is to be inserted in the agenda for the July Council meeting, and it will be discussed again at that time, before it is presented to the House of Delegates.

2. *Honorariums for guest convention speakers.* By consent the Council approved the action of the Executive Committee in setting a maximum of $200.00 on honorariums to be paid guest speakers who appear on the annual convention program on more than one day.

The Council also concurred in the Executive Committee's recommendation regarding section speakers that an honorarium will be paid on a per day basis provided the speaker also appears on the general program.

3. *Interviews of Indiana physicians by Columbia University.* Dr. Everly referred to the Council a letter which he had received from the chairman of the Commission on Medical Education and Licensure concerning complaints received from some physicians in the state about the type of survey being made. **By consent the Council approved the recommendation of the Executive Committee that in the future the association should not approve any survey until it has all the facts, and is fully aware of what the survey might encompass.**

4. *Re-election of Dr. Bibler to AMA Board of Trustees.*

Dr. Everly reported that many complimentary letters had been received concerning Indiana placing the name of Dr. Bibler in nomination for re-election to the Board of Trustees of the American Medical Association.

5. *Building matters.* Dr. Everly reported that he had obtained a much lower quotation than the original estimate for installation of the drop ceiling and new lighting in the basement, and this quotation had been accepted. This work had been previously approved by the Council.

6. *Complaint from a voluntary health agency.* The chairman presented, for the information of the Council, a complaint from one of the agencies which had been approved by the Commission on Voluntary Health Agencies. In its letter of approval the commission stated, "We hope that you will see fit to use the fact that your organization has been recognized by the Indiana State Medical Association on your letterhead, indicating, of course, that this recognition is on a yearly basis." The agency objected to the idea of having to list approval "on a yearly basis," which intimates that the agency might be on probation. In discussing this, Dr. Gosman, a member of the Commission on Voluntary Health Agencies, said this was a misinterpretation of the letter sent out by the commission.

**Motion duly made, seconded, put to vote and carried "that it just be approved by the state medical association and then when we make our approval, if they continue to use it, make an issue of it then."**

## Economic and Organization Matters

1. *Remission of state dues.* The Council voted the remission of state dues as follows:

*Vanderburgh County*—One member, because of ill health and hardship, **on motion duly made, seconded, put to vote, and carried.**

*Vigo County*—one member, due to illness, **on motion of Dr. Cavins, duly seconded, put to vote, and carried.**

*Tippecanoe County*—one member, because of serious illness, **on motion of Dr. Petrich, duly seconded, put to vote, and carried.**

*Allen County*—one member, because of ill health and retirement, **on motion of Dr. Popp, duly seconded, put to vote and carried.**

*Elkhart County*—one member, because of illness, **on motion of Dr. Bennett, taken by consent.**

2. *Status of Nursing Homes.* Dr. Robert H. Rang discussed the proposal presented to the Daviess County Hospital (140 beds) by the United States Steel Company to build a 48-bed nursing home to be operated in conjunction with the hospital as an extended care and convalescent home, and to be administered by the hospital. If the Medicare bill passes, such an institution would be needed in Daviess county. Inasmuch as the County

Council would not support this with a bonding issue, United States Steel proposed to underwrite the financing of the project on a lease-back arrangement, which, after a certain length of time, would give the hospital title to the nursing home. On presentation to the State Board of Accounts, that board said it had no clear decision on such a matter and the Attorney General's opinion would have to be sought as to whether or not it is legal for a county hospital to enter into a lease-back agreement for the erection of physical property.

Dr. Rang said his county would appreciate the support of the State Medical Association in securing a favorable regulation from the Attorney General on this question.

This was discussed by Drs. Offutt and Edwards. No action was taken by the Council.

3. *Nominations of two members for Editorial Board.* **Dr. Popp nominated Dr. Alvin J. Haley, Fort Wayne (general practice), to succeed himself.**

**Dr. Kerr nominated Dr. Richard Hawkins, Bedford (pediatrics).**

**Dr. Steen nominated Dr. Franklin F. Premuda, Hammond (pediatrics), to succeed himself.**

**On motion of Drs. Steen and Petrich the nominations were closed.** The Council will vote at its fall meeting for two of these nominees for membership on the Editorial Board for the three-year term ending December 31, 1968.

4. *Blue Shield Board of Directors.* The chairman of the Council reminded councilors of Districts 2, 3, 6 and 11 that their districts should nominate this year one member each for the Blue Shield Board of Directors, for the three-year term beginning March, 1966.

5. *Blue Shield Board members-at-large.* The terms of Drs. Bernard D. Rosenak, Indianapolis (internal medicine), E. T. Edwards, Vincennes (general practice), and Lowell I. Thomas, Indianapolis (orthopedic surgeon), will expire in March, 1966. **Dr. Donato nominated these three men to succeed themselves for the three-year term beginning March, 1966.**

**Dr. Popp nominated Dr. Maurice E. Glock, Fort Wayne (internal medicine).**

**On motion of Drs. Steen and Neumann, the nominations were closed.**

**On motion of Drs. Popp and Petrich, election of three members-at-large for the three-year term beginning March, 1966, was deferred until the January, 1966 Council meeting.**

## New Business

1. *Michigan Association of Professions.* Dr. Bennett reported on his attendance at the meeting of the Michigan Association of the Professions in Grand Rapids on March 26 and 27, saying that he felt that this is a worthwhile organization. Membership in the Michigan Association is at present restricted to architects, lawyers, dentists, teachers, professional engineers, physicians, pharmacists, and veterinarians. "I think this is a good exposure for these other professions to hear organized medicine speak in their presence and as a friend. And I think if and when the time comes for such an organization in Indiana that organized medicine should support it."

**On motion of Drs. Neumann and Bennett, the Council voted to refer this matter to the Executive Committee for implementation, if necessary.**

2. The chairman announced that Dr. Corcoran had asked him to present the proposal that each county medical society be requested to sit down and decide what medicine's stand should be on the problems confronting it today and where organized medicine should travel from now on.

**On motion of Drs. Steen and Popp this matter was tabled until Dr. Corcoran is present.**

## Reports of Guests

1. DR. A. C. OFFUTT, State Health Commissioner, spoke in detail on the *area-wide planning program*, "to bring the Council up-to-date on the progress or lack of progress that the State Board of Health has made with its request for a grant, and for whatever consideration the Council might wish to give to this matter."

Dr. Edwards called attention of the Council to the fact that the Council, about a year ago, had rejected participation in the Indiana Hospital Association proposal for planning area-wide facilities and had recommended that this program be carried out through the established functions of the State Board of Health. Dr. Edwards said, "What Dr. Offutt has said today actually is a continuation of that philosophy and if the Council still feels the same way, **I think it behooves the State Medical Association to support his position for funds for this program by writing letters to our Congressmen and Senators and those in the Public Health Service, and I so move. Motion seconded by Dr. Neumann, put to vote, and carried.**

2. DR. LESTER H. HOYT, member of the Professional Advisory Committee of Blue Cross, reported that at the annual meeting of Blue Cross on March 25 all members of the board of directors were re-elected. Judge Lloyd Claycombe is chairman of the board, and Guy Spring is president. Dr. Hoyt said, "Operating expenses for the past year were less than four percent, which is an outstanding figure. They have been operating in the black and now have reserves of approximately 95% of the recommended amount. There also has been a gain in membership."

## Matters from Committees and Commissions

1. *Student Loan Committee.* Dr. Bibler, chairman, called attention to the cash balance in the Student Loan checking account of $2,512.24, and **on motion duly made and seconded, the Council approved the recommendation of the Committee on Student Loan that this amount be transferred to a savings account at four percent interest.**

**On motion of Drs. Donato and Neumann, the Council approved the recommendation that Mr. Hollowell be authorized to send certified letters to nine physicians who are delinquent in the repayment of their student loans, requesting payment.**

Dr. Bibler also reported that the committee had changed its phraseology to "Student Investment Fund, inasmuch as the committee is not spending money—it is investing in future doctors of medicine."

2. *Council Liaison Committee with Blue Shield.* Dr. Bennett reported that the Blue Shield board had not met since the last Council meeting.

3. *Council Liaison Committee with I. U. School of Medicine.* This committee is scheduled to meet in the near future.

4. *Council Liaison Committee with Blue Cross.* Dr. Taylor, chairman, presented the following report:

"Your Council liaison member has attended two board of directors meetings, the annual meeting, and several Blue Shield Medical Advisory Committee meetings since being appointed to the position last October.

"From the information furnished at the annual meeting, it appears that Blue Cross continues to grow and expand with a sound financial basis and maintains a strong competitive position with the commercial health insurance companies.

"All the physicians on the board of directors of Blue Cross were re-elected to the board at the annual meeting.

"At the director's meeting preceding the annual meeting, a rather lengthy report was received from the Special Committee on Proposed Hospital Rate Increases. This committee was created in 1959 and has continued to the present time with increasing activities. As its name implies, it reviews and recommends action concerning increases in all categories of hospital charges submitted by participating hospitals to Blue Cross.

"Recently there is evidence that this committee is extending its functions to include evaluation of proposed extension of hospital services and increased bed space. The committee chairman in his report indicated that these factors would be considered in terms of community need and in terms of area availability of similar services and facilities. The implications of such a precedent becoming established fact is readily apparent.

"The makeup of this hospital rate committee is of concern to your liaison member. The membership includes three hospital administrators, three public representatives and representatives of the Blue Cross staff. The president and the director of planning of the Indiana Hospital Association serve as ex-officio members. There is no physician representation on this committee and action by this committee can certainly have direct as well as indirect effect on all of us as practitioners of medicine.

"I strongly urge that the council go on record that at least one physician be appointed as a member of this Blue Cross committee and that the physician members bring this to the attention of the Blue Cross board and request that such a member or members be appointed."

**Dr. Taylor moved the acceptance of this report and, further, that the physician members on the Blue Cross board seek M.D. membership on the Hospital Rate Committee. Motion seconded by Dr. Bennett, discussed by Drs. Neumann, Hoyt, and the chairman of the Council, put to vote, and carried.**

5. *Reports of Commissions.*

a. *Commission on Convention Arrangements.* Dr. John Mader, chairman, reported that his commission had met (April 4, 1965) and had added one more topic to the Medical-Socio-Economic Conference which is to be held from 10:30 to 12 noon on Thursday, October 14, 1965, that is, "Current Status of Health Legislation." Otherwise the program as presented to the Council is complete.

Regarding instructional courses, it was the consensus of the commission that four or five courses should be offered, that these should be of the panel type in which three instructors would be allowed about ten minutes each to speak, and then the subject would be thrown open for discussion or a question and answer period. Each course will run for one hour. The commission is working with the Indiana Academy of General Practice in formulating these courses.

b. *Commission on Legislation.* Dr. Dwight Schuster, chairman, thanked the members of the Council, the executive secretary and the field men for the tremendous amount of work which they had done during the last General Assembly. He reported that at least 120 bills were reviewed by the Commission and the field men.

Dr. Schuster reviewed the seven bills which were the result of either a mandate from the House of Delegates, or in which the state medical association, through the course of events, had participated actively in the formulation. These were:

(1) Public Health Code, providing for reorganization of local boards of health. (Passed).
(2) Medical Records, providing for confidentiality of health records. (Passed).
(3) Graduate Medical Education, concerning relationship of interns and residents with the State Board of Medical Registration and Examination. (Passed).
(4) Medical Licensure, concerning reciprocity or endorsement, and qualifications of graduates of foreign medical schools. (Passed).
(5) Medical care of married minors and their children. (Passed).
(6) Division of medical care and treatment in the Department of Corrections. (Vetoed by the Governor).
(7) Standards for manufacture and sale of optical lenses. (Did not pass).

(See April, 1965 *ISMA Journal*, pages 346-350 for detailed report).

Dr. Schuster also commented briefly on the new Mills bill, HR-6675.

c. *Commission on Special Activities.* Dr. H. C. Ochsner, secretary, reported that the commission had discussed the impartial medical witness plan which had been proposed by the State Bar Association, and the commission is awaiting further suggestions from the Bar Association.

## Date for Summer Meeting

**On motion of Drs. Petrich and Steen, July 18, 1965, was set for the next meeting of the Council.**

There being no further business, the meeting was adjourned. ◄

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*(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.*

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AUGUST 1965

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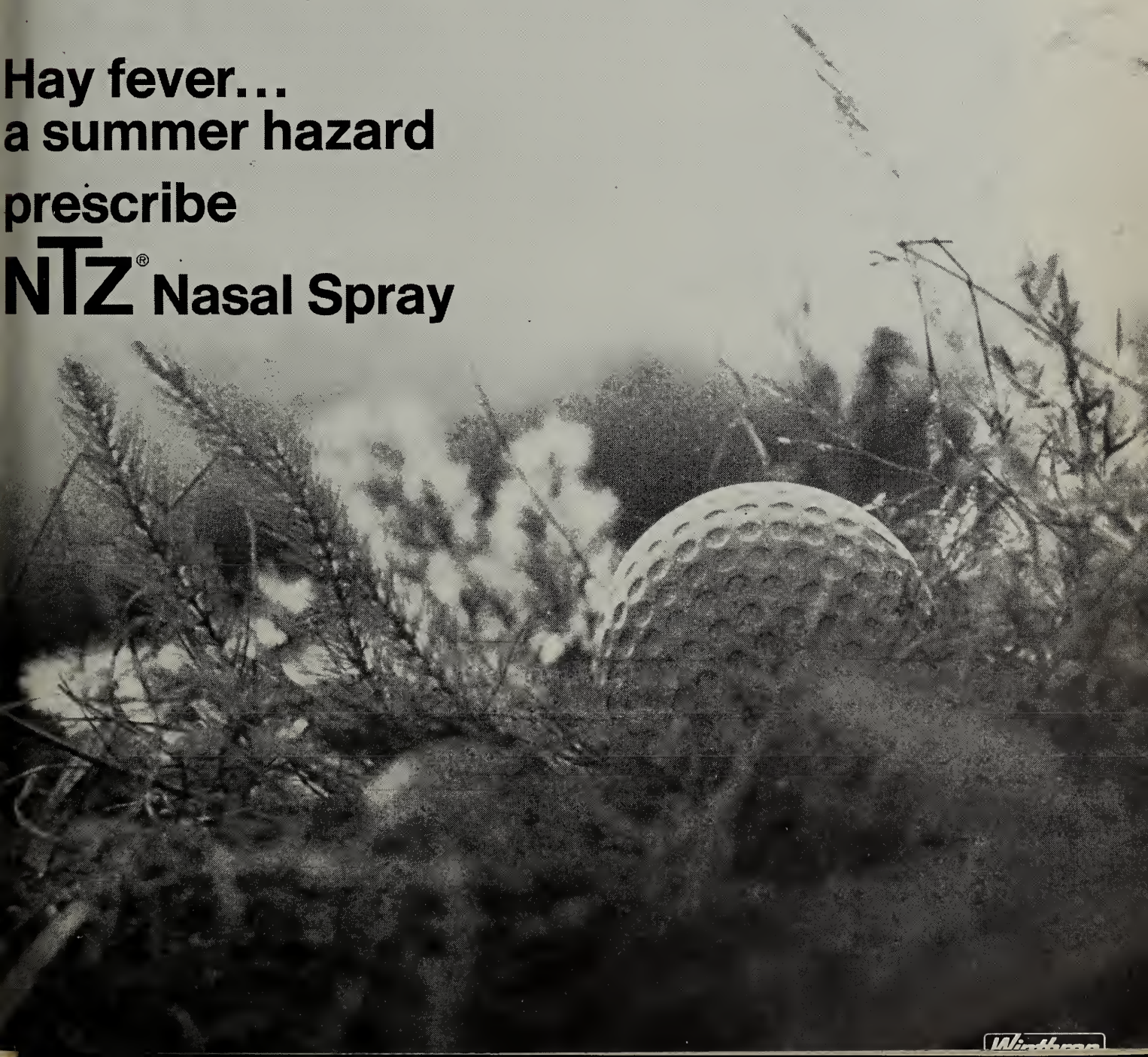
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| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | May 19, 1966 |
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| 11. | Fred C. Poehler, La Fountaine | Max M. Earl, Kokomo | Peru, Sept. 15, 1965 |
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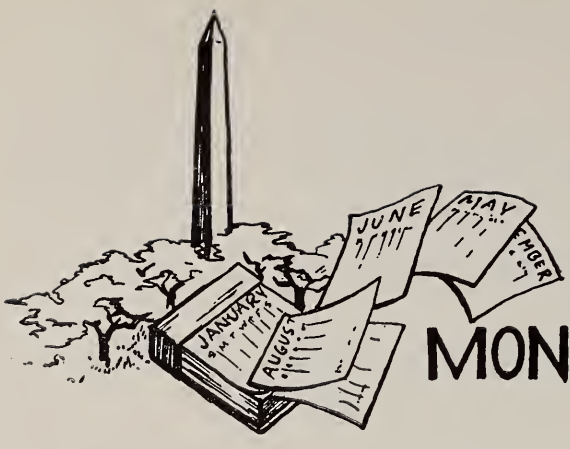
There are advantages to employers, too. Blue Cross–Blue Shield cuts the paperwork, eliminates the administrative details, keeps an employer from getting into the claims-handling business.

If you want to join Blue Cross–Blue Shield, get more information from the office nearest you.

# "I don't know what we would've done without Blue Cross Blue Shield."

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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D. C.—The Public Health Services Advisory Committee on Immunization Practices has predicted increased amounts of influenza in the coming season (1965-66).

The committee again recommended immunization for persons in groups who experience high mortality from epidemic influenza. Vaccination, the committee said, should begin about Sept. 1, and ideally be completed by mid-December.

"It is important that immunization be carried out before influenza occurs in the immediate area since there is a two-week interval before the development of antibodies," the committee said.

Groups for which annual immunization were recommended:

"(a) Persons at all ages who suffer from chronic debilitating disease, e.g., chronic and cardiovascular, pulmonary, renal or metabolic disorders; in particular:

"1. Patients with rheumatic heart disease, especially those with mitral stenosis.

"2. Patients with other cardiovascular disorders such as arteriosclerotic heart disease and hypertension, especially those with evidence of frank or incipient cardiac insufficiency.

"3. Patients with chronic bronchopulmonary disease, for example, chronic asthma, chronic bronchitis, bronchiectasis, pulmonary fibrosis, pulmonary emphysema, pulmonary tuberculosis.

"4. Patients with diabetes mellitus and Addison's disease.

"(b) Persons in older age groups.

"(c) Pregnant women.

"(d) Patients residing in nursing homes, chronic disease hospitals, and other such environments should be considered as particular risks since their more crowded living arrangements may allow for greater spread of disease once an outbreak has been established."

The committee reported that there were cases of influenza in a majority of the states in the eastern two-thirds of the country during last season (1964-65) but that the amount of the disease in the United States as a whole was limited. There was no major epidemic anywhere in the country and most states in the far west were unaffected.

The committee said that Type A influenza viruses may predominate in 1965-66 but that Type B outbreaks also could be expected.

As to vaccine efficacy, the committee said:

"Influenza vaccine has consistently shown a substantial protective value when the viruses incorporated in the vaccine were antigenically similar to those causing the epidemic disease. Exceptions to the vaccines' apparent effectiveness have occurred in instances when the prevalent virus underwent a major antigenic shift after vaccines had been formulated. Careful study goes into the annual design and updating of the composition of influenza vaccines. The final selection of components reflects the best judgment regarding a potent, contemporary vaccine.

Continued



# Lirugen™

## is *truly* a one shot measles vaccine.

An efficacy rate of 99% has been demonstrated with Schwarz Strain live measles vaccine (Lirugen). In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine. Additional special passages of the original Edmonston Strain by Schwarz resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.


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Continued

"That influenza vaccine prevents mortality from influenza, particularly among the aged and chronically ill, is based upon inference. It is presumed that vaccine protection demonstrated in studies among younger persons is similar among the aged and chronically ill, the group at particular risk of death should they acquire the disease. It is further assumed that such protection against clinical disease serves to protect them also against mortality associated with epidemic influenza."

## STIFF CONTROLS IMPOSED ON AMPHETAMINES, BARBITURATES

Congress has approved legislation imposing stiff Federal controls on the manufacture and sale of amphetamine and barbiturate tablets.

The American Medical Association supported the legislation which was aimed at curtailing use of the drugs as "pep pills" and "goof balls."

In requesting the legislation, Food and Drug Administration Commissioner George P. Larrick told Congress that half of the nine billion amphetamines and barbiturates manufactured annually have been sold on the black market to teenagers, truck drivers and persons searching for a substitute for marijuana, heroin or cocaine.

The version of the legislation as finally approved left it up to the Secretary of Health, Education and Welfare whether he utilizes an advisory committee before deciding whether depressant or stimulant drugs have a bad effect on a person's personality. The AMA had recommended that this provision be mandatory.

The new law also requires detailed bookkeeping on the drugs by manufacturers and wholesalers. Druggists' sales records of the pills must be open for inspection by FDA agents. This provision aimed at keeping track of the retail distribution of the prescription drug.

The record-keeping and inspection provisions will not apply to licensed physicians with respect to drugs received and used in the course of their practice, unless the practitioner regularly engages in dispensing the drug to his patients for which they are charged, either separately or together, with charges for other professional services.

In its reports, the House and Senate committees stated that the legislation was intended "to require record-keeping and to permit inspection in the case of those physicians who maintain a supply of pharmaceuticals or medicinals in their offices from which they compound prescriptions for their patients for a fee." The House committee report contained identical language.

The new law also provides that a prescription for a depressant or stimulant drug cannot be filled or refilled more than six months after its date of issue, nor can such a prescription be refilled more than five times. However, a physician can renew the prescription either in writing or orally, if promptly reduced to writing and filed by the pharmacist filling it.

## CIGARETTE PACKS WILL BEAR HEALTH WARNING

Congress has approved legislation to require a health warning on all cigarette packages.

The compromise legislation, worked out by House-Senate conferees last week, would bar any similar warning in cigarette advertising for four years.

The warning required by the legislation reads: "Caution: cigarette smoking may be hazardous to your health."

The new law leaves to the manufacturer's discretion the exact location of the warning but says it must be in a conspicuous place. It also requires that the warning must appear in conspicuous and legible type in contrast by typography, layout or color with other printed matter on the package.

Continued

# Butazolidin®
brand of
phenylbutazone

# in osteoarthritis



Geigy

**Therapeutic effects**
A number of investigators report improvement in about 75% of cases. Relief of pain and stiffness is the predominant response. Frequently, there is also a significant improvement in function. The beneficial effects of the drug are usually seen by the third or fourth day of treatment.

There is general agreement that milder cases of osteoarthritis are preferably treated by simple analgesics. In many patients, however, this mode of therapy fails to give sufficient relief. Because steroids are not very effective in this form of arthritis, phenylbutazone affords the drug therapy most capable of relieving the more severe cases. For best results, it is recommended that treatment with phenylbutazone be combined with physiotherapy and other appropriate supportive measures.

**Dosage**
The initial daily dosage in adults is 300-600 mg. in divided daily doses. In most instances, 400 mg. daily is sufficient for maximum therapeutic response. A trial period of one week is adequate to determine the effects of the drug; if there is no improvement, discontinue the drug. When improvement does occur, dosage should be promptly decreased to the minimum effective level: this should not exceed 400 mg. daily, and is often achieved with only 100-200 mg. daily.

**Precautions**
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

**Warning:** If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

**Side effects**
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

**Contraindications**
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannof be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

**Note:** The physician should be fully aware of dosage, precautions, side effects and contraindications as contained in the complete prescribing information.

**Butazolidin alka**

| Each capsule contains: | |
|---|---|
| Butazolidin, brand of phenylbutazone | 100 mg. |
| dried aluminum hydroxide gel | 100 mg. |
| magnesium trisilicate | 150 mg. |
| homatropine methylbromide | 1.25 mg. |

**Butazolidin**
brand of phenylbutazone
Tablets of 100 mg.

Geigy
Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York
BU-3143

## MONTH IN WASHINGTON

Continued

The prohibition against any action by any government agency in regard to cigarette advertising applies most directly to the Federal Trade Commission.

The FTC had announced plans to require cigarette advertising to be accompanied by a health warning similar to that which the legislation requires on the package.

If no further legislation is passed by Congress by July 1, 1969, the FTC will be free to go ahead with its advertising proposal.

During the next four years, the FTC and the Department of Health, Education and Welfare will submit periodic reports to Congress on whether the package label has any effect on cigarette consumption.

The congressional decision to require a health warning on cigarette packages stemmed largely from a report by the U.S. Surgeon General's office which linked smoking to lung cancer and other disease. ◄

## *About Our Cover*



The man who contributed most to the progress of medicine in the early American states and who doggedly sought the freedom of American physicians from European dominance was Dr. Benjamin Rush.

Brilliant, well educated, domineering, impatient, impulsive and acrimonious in his attacks upon contemporary physicians, Dr. Rush still had the profound dedication of his students and the obstinate confidence and affection of his patients. He comforted them and was never too tired or too busy to try to care for them.

Dr. Rush was interested in every phase of life around him and wrote and published on many subjects. He advocated penal reform, abolition of slavery, better sanitary systems and better general education. One of the first to advocate preventive medicine, he was an ardent proponent of inoculation and later, of vaccination against smallpox.

Born December 24, 1745 (old calendar) or January 4, 1746 (new calendar — England did not adopt the Gregorian calendar until 1752), Dr. Rush received his Bachelor of Arts degree from the College of New Jersey (now Princeton) in 1760. He apprenticed himself to a busy Philadelphia physician at the age of 15 and remained there for five years. He then enrolled in the University of Edinburgh, Scotland in 1766 and received his Doctor of Medicine in 1768.

He returned to Philadelphia the next year to enter practice. Elected to Congress in 1776, Dr. Rush was among the signers of the Declaration of Independence and was also influential in framing the Constitution. As a teacher he exerted more influence on the medical profession in America following the Revolutionary War than any other person.

The greatest test of Dr. Rush's ability as a physician and medical leader came in the epidemic of yellow fever in 1793. Thousands of citizens fled Philadelphia, including many physicians, but Dr. Rush remained to fight the disease and the city officials, advocating that the streets be cleaned, the ponds and marshes drained and something be done about the swarms of mosquitoes that plagued the city.

He doggedly stuck to his ideas and concepts, through further epidemics of yellow fever in 1794, 1796 and 1798, absorbing more and more criticism from his fellow physicians and citizens of the city. He continued working into his 68th year, calling on patients as late as April 13, 1813. He died April 19, 1813.

Justifiably called the first great physician in the United States of America, Dr. Rush typifies the general practitioner, whom we salute in this issue.

Our sincere thanks to Parke, Davis & Company for allowing us to reproduce one of the paintings from their "History of Medicine in Pictures" series.©—J.F.S.

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*...nothing, that is, except the*

## *sedative-antispasmodic action of* DONNATAL®

Functional disturbances of gastrointestinal tone and motility present the physician with an all too common reaction to the stressful dilemmas and frustrations of modern living.[3,6]

For their dependable control, no better spasmolytic has ever been discovered than the *natural* belladonna alkaloids in combination with phenobarbital, as in DONNATAL.

Phenobarbital, as a mild sedative, has the benefit of long use and a reassuring record of freedom from unexpected and untoward reactions. In allaying subjective tension, it helps to prevent emotional stimuli from provoking or intensifying visceral spasm.

The *natural* belladonna alkaloids in DONNATAL—conforming to the classic formulation by Vollmer[5]—selectively include only the therapeutically desired alkaloids in precisely and optimally balanced ratio. The clinical uncertainties of the variable tincture and extract of belladonna are thus avoided.

Further, a recent pharmacological study has confirmed that the antispasmodic effectiveness of the belladonna alkaloids in DONNATAL is measurably potentiated by the presence of phenobarbital.[8]

Over the years, the professional consensus has reflected broad clinical confidence in the marked benefits to be achieved by DONNATAL in a wide range of visceral disorders... in peptic ulcer,[1,6] functional bowel distress,[1] gastrointestinal spasm and discomfort,[2] and other functional disturbances of visceral smooth muscle.

CONTRAINDICATIONS: Glaucoma, advanced renal or hepatic disease or hypersensitivity to any of the ingredients.

PRECAUTIONS: Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction as in prostatic hypertrophy.

SIDE EFFECTS: Blurring of vision, dry mouth, difficult urination or flushing and dryness of the skin may occur at higher dosage levels, rarely at the usual dose.

*This one at Oak Creek, Castle Rock, Arizona

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**A. H. ROBINS CO., INC., Richmond 20, Va.**

*Prescribed by more physicians than any other antispasmodic —well over 5 billion doses!*

# Donnatal®

Robins

| *In each Tablet, Capsule or 5 cc. Elixir* | | *In each Extentab®* |
|---|---|---|
| 0.1037 mg. | hyoscyamine sulfate | 0.3111 mg. |
| 0.0194 mg. | atropine sulfate | 0.0582 mg. |

| *In each Tablet, Capsule or 5 cc. Elixir* | | *In each Extentab®* |
|---|---|---|
| 0.0065 mg. | hyoscine hydrobromide | 0.0195 mg. |
| 16.2 mg. (¼ gr.) | phenobarbital (¾ gr.) | 48.6 mg. |

(Warning: May be habit forming.)




# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Protecting The Public

A half-century ago public confidence in business was at a low ebb because a small and unscrupulous group had threatened the credibility of all advertisers.

The problem had grown so serious that the government appeared ready to step in with restrictive measures. The vast majority of honest and progressive businessmen, however, believed the matter could best be handled by self-regulation.

It was in such circumstances that the Indianapolis Better Business Bureau was born, being one of the first four such agencies in the country.

There is no way of knowing how many people have been protected from fraudulent or unethical advertising or how much money has been saved because of this organization. But no one can dispute its beneficial effect.

The Central Indiana Better Business Bureau, successor to the original group, is supported by 1,297 member firms in irrefutable evidence of the efficiency of the bureau's work. It is also evidence that these firms are eager to protect the public and have earned the confidence they now enjoy.

In its years of existence, the bureau's service to the community has increased markedly. It is interesting to note that originally complaints far outnumbered inquiries. Now the proportion is reversed, indicative of the effective job the bureau has done.

It is a big and endless task and one which is requiring an expanded staff and facilities. Consequently the Central Indiana Better Business Bureau is conducting a city-wide campaign extending through April 30 for 100 new members.

There ought to be no hesitancy about joining an organization that has served the community so well. The bureau is an example of self-regulation at its best and it should be congratulated on its foresight in preparing for the future.—*Indianapolis News*, April 20, 1965.

## Compulsory 'Fedicare'

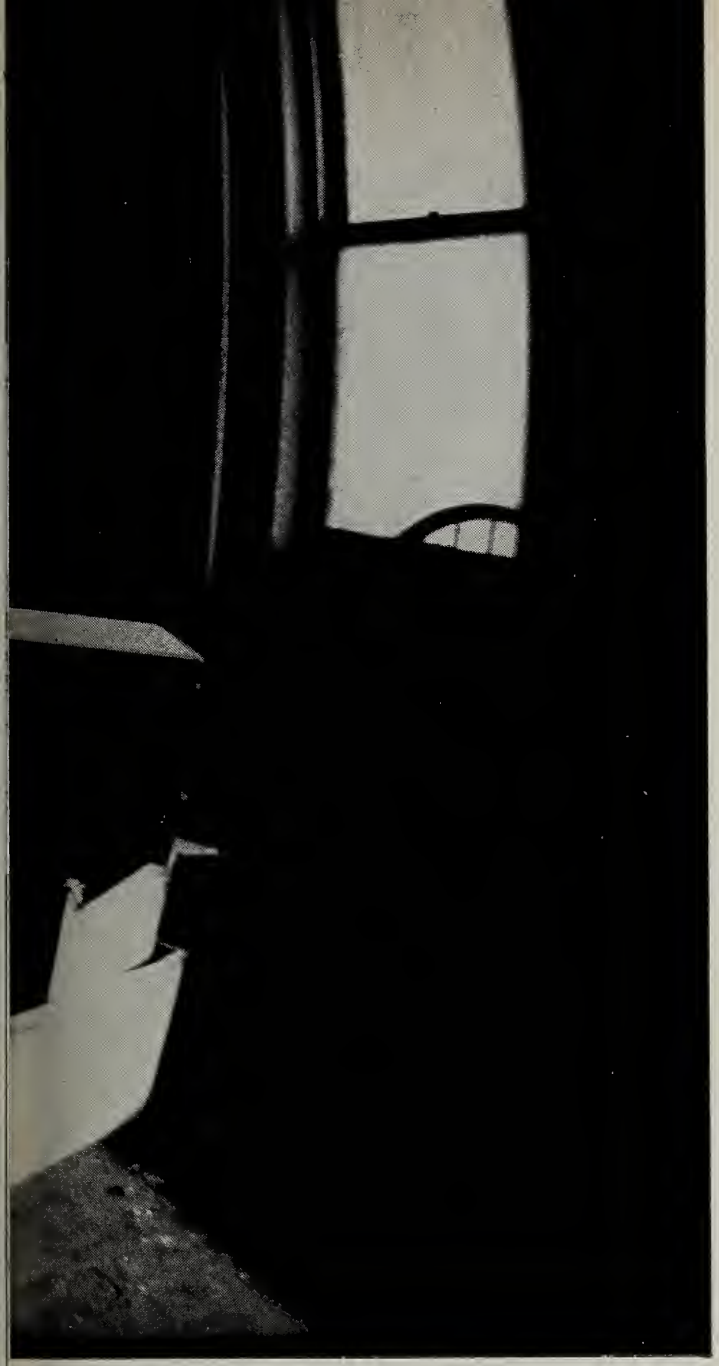
Some people have suggested the administration's proposed Medicare program be called "Fedicare" instead, alluding to the expansion of Federal interference in the field of medicine.

One of the many sad results if Medicare is passed could well be a serious decline of private health insurance programs for people over 65, with the government dictating the terms. Sen. Carl Curtis, R.-Neb., points to some of these dangers:

"If the supplemental health and Medicare portions are enacted, it will be the beginning of the end of private hospital and medical insurance for individuals over 65. Great progress has been made by private companies in providing insurance for those over 65. All of these benefits will come to an end if the Federal government invades the field and acts as insurer. . . .

"While the government is the insurer and takes the risk for the supplemental health benefits, the administration of the program will be handled by outside carriers, supposedly such organizations as Blue Cross or insurance companies. Those outside carriers will be selected by the secretary of health, education and welfare. The secretary, in determining what companies he shall employ as outside carriers, will be able to oversee the work of such carriers and their con-

Continued



**ide effects and precautions:** The transitory rowsiness which may occur with hydroxyzine HCl usually disappears spontaneously in a few ays with continued therapy, or is correctable y dosage reduction. Dryness of the mouth may e seen with higher doses. Involuntary motor ctivity has been reported in hospitalized atients on higher than recommended doses. ydroxyzine HCl may potentiate CNS depres- ants, narcotics such as meperidine, barbitu- ates, and anticoagulants. In conjunctive use, osage for these drugs should be decreased. ecause drowsiness may occur, patients should e cautioned against driving a car or operat- ng dangerous machinery. **Parenteral Solution recautions and contraindications:** This dosage rm is intended only for I.M. or I.V. adminis- ration and should not, under any circum- tances, be injected subcutaneously or intra- rterially. When the usual precautions for I.M. njection have been followed, reports of soft issue reactions have been rare. I.V. adminis- ration should be slow, no faster than 25 mg. er minute, and should not exceed 100 mg. in ny single dose. Particular care should be used o insure injection only into intact veins; a few nstances of digital gangrene occurring distal a the injection site have been attributed to nadvertent intraarterial injection or periarte- ial extravasation, both of which should be voided. **More detailed professional informa- ion available on request.**



tracts with doctors."

Concludes Curtis: "Ultimately all will toe the mark."—*Indianapolis News,* April 15, 1965.

## Size Is No Answer

Indiana, as with many states, is now concerned with the possibility that we may soon face a serious shortage of physicians. And there has been much thought given to either enlarging the present medical school of Indiana University or starting a new institution.

It was of more than a little interest to note that Dr. James Z. Appel of Lancaster, Pa., President-Elect of the American Medical Association, is firmly opposed to a huge school where teacher-student relationship seems to get lost.

Nor is he the first man who has given long thought to this problem to voice this view. Indeed, the consensus among those who appear qualified to pass professional judgment on this issue seem in near-solid agreement that medical school bigness brings about certain built-in hazards to the educational system.

Dr. Appel made, in his address to the Indiana University Alumni Association, a stirring and well-reasoned appeal that the so-called "Art of Medicine" be nurtured within the framework of a medical education.

The "Art of Medicine," is something he defines as that almost undefinable skill we have all seen demonstrated by some doctors which gives them a total picture of an individual patient. And he stressed the absolutely vital necessity of each doctors knowing as much as possible about the personality, pressures and emotional tensions each patient experiences before treatment for any ailment is begun.

It is that almost mystical "sixth sense" that Dr. Appel fears may be lost when medical schools become so large teachers and students lost contact with one another. So while he sets no limit—knowing no specific figure for an ideal medical class size — he is firmly opposed to enlarging any institution to the point of diminished educational returns.

Moreover, he said, staffing these schools

is the biggest problem facing medical educators today. Starting a new medical school from scratch means lining up faculty members well in advance of letting contracts for new buildings.

It is a complex problem indeed and one which will not be really solved. But Dr. Appel's warning words spell out the need for long and careful study before Indiana makes a decision on supplying more physicians for our expanding population.—*Indianapolis Star*, May 17, 1965.

## The Doctors Dig In

The dedication of the medical profession is highlighted by a task Marion County physicians have set for themselves.

Local doctors plan to raise $1,550,000 in the United Hospital Campaign conducted by the Indianapolis Hospital Association. That represents 10 per cent of the over-all $15,500,000 effort, an impressive ratio when one considers there are roughly 1,000 physicians in the county and 800 in active practice.

The doctors no doubt are involved in this campaign for better hospitals because they know better than anyone else what improved facilities can mean in healing the sick and saving lives. Yet it is ironic that, as Marion County's physicians participate so actively in the drive for better hospitals, the medical profession generally is under attack by those who would have America's medical services subordinate to the Federal bureaucracy.

For their opposition to such schemes, America's doctors have been in some cases painted as lacking in compassion and humanity.

That has always been an unfair and politically motivated characterization. Here in Marion County, the efforts of local doctors in the United Hospital Drive are further evidence that the nation's medical profession is one of the finest and most dedicated in the world—*The Indianapolis News*, June 9, 1965.

## Socialized Syndrome

The aches and pains of England's socialized medicine have been aired in a book recently published. Actually the treatise is a guide on how to obtain legitimate benefits from the tax-supported service.

The book's list of abuses indicated that the socialistic dream world of everything for the masses costs and costs in the long run. Some people go to the library, the book contends, read up on an illness and its symptoms and then hurry to a hospital. What they want is free board and room.

One London girl tripped to the hospital and announced "My feet are sore. I've been dancing all night." The most popular ruses used by fakers are alleged stomach pains, backache and a thumping heart. The thumping heart is often produced when the would-be patient runs up and down the sidewalk outside the hospital to produce same.

A Mr. Y seeks hospital treatment by complaining of aching feet, the book recalls. He has not worked in years but walks all night to produce the sore feet that he hopes will give him a hospital stay.

A night watchman's job would produce more practical results.

The cost of England's National Health Service will continue to rise unless the service is used properly, conclude the authors.

This is small consolation for the economic pain it is now causing taxpayers as the bite continues to grow bigger.—*The Indianapolis Star*, June 21, 1965. ◄

**The September issue of *The Journal* will contain the complete program and reports to be presented at the 116th Annual Convention of the Indiana State Medical Association, October 11-14 in Indianapolis.**

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 58 — August 1965 — Number 8

# Salt Restriction in Acne Vulgaris

L. EDWARD GAUL, M.D.
Evansville

THE PATIENT, a 15-year-old boy, was being examined for pustular and systic acne of three years' duration. His chin and submental region displayed an acute outbreak. His mother, worried about scarring, raised this question, "Is it healthy for him to eat so much salt knowing that his father has high blood pressure? He, too, had pimples in his teens."

A definitive reply was not given, but the patient was told that limiting salt intake would cause no harm and his cooperation would lighten the concern of his parents. Two weeks later, there was an unexpected improvement, impressive enough to suggest a study of salt nutrition in acne.

More patients and parents were queried about their habits of food seasoning. The impression grew that adolescents use salt freely and in some a "salt hunger" was suspected. Three managers of large teenage eating places were also interviewed. Two described heavy use of salt, especially by boys, adding that it was "spooned up" from the plate with bites of french fries. All three commented on the excessive use of ketchup by teenagers.

The following foods, consumed freely by teenagers, contain the respective amounts of sodium/100 gm: ketchup 3.2 gm, salad dressing 1.46 gm, mustard 2.96 gm, processed cheese 1.5 gm, butter 0.98 gm, milk 0.05 gm, ice cream 0.01 gm, frosted cake 0.2 gm, chocolate sandwich cookies 0.2 gm, bread 0.8 gm, crackers 1.1 gm, roasted peanuts 0.46 gm, bologna 1.3 gm, cured ham 1.1 gm, franks 1.3 gm, popcorn 2 gm, potato chips 0.34 gm, soft drinks 0.004 gm and chocolate syrup 0.06 gm.

One patient was eating 120 gm of olive butter daily, ingesting 3 gm of salt from this one food. Another was consuming four grilled cheese sandwiches, a can of soup, a quart of milk and a pint of ice cream for lunch, about 5 gm of salt at one meal.

The pubertal growth spurt also increases the salt intake during adolescence. During this period the appetite is phenomenal and it is often assuaged by well-seasoned, taste-appealing, packaged or bottled foods, including a choice of salted snacks.

The body contains about 100 gm of salt. Complete deprivation of salt for 30 days leads to a loss of about 1/5 of this which substantiates the remarkable ability of the kidneys and sweat glands to conserve body sodium.[1] The intake of salt in the United States is estimated to be 7.5 to 18 gm/day, but seemingly no dietary allowances for sodium or potassium have been established.[2] Normal body needs are easily met by the use of unsalted foods[3], or less than 1 gm/day[1] or even 1/2 gm/day.[4] The wide discrepancy between body needs and the amount of salt ingested broadened interest in its possible significance in acne.

## Materials and Methods

The availability of a semiquantitative test for urinary chloride furnished a necessary control for this study. Known as the Fantus test, it is carried out as follows: Ten drops of urine are placed in a test tube to which is added one drop of a twenty percent solution

of potassium chromate. A solution of silver nitrate, 3.9%, is added drop by drop to the urine sample until a brown color is produced. Each drop of silver nitrate required represents 1 gm of salt/L of urine. It was not considered practical to test 24-hour specimens in office patients. The test results therefore represent only a sampling of morning or afternoon specimens for the approximate quantity of chloride present.

The urine of 30 patients with acne in various stages was tested. The quantity of chloride ranged from 12 gm/L up to 20 gm/L, with most of the patients being in the range from 15 to 20 gm/L. The patient who provided the incentive for this study was seen a month later with a flare-up almost as severe as the one observed at the initial visit. At this time the urinary chloride was found to be 18 gm/L. In spite of encouragement and detailed instruction to him and his parents, the chloride level in his urine was never less than 14 gm/L. This experience was a reminder that only dedicated patients and parents who had the zeal and knowledge to follow diet instructions would be suitable for this study.

A major difficulty besetting any study of acne therapy is the lack of means to judge results. Photographs, counting lesions and taking imprints were considered, but it was finally decided to record the pattern distribution and the type of lesion predominant in the patterns. Acute lesions such as pustules and inflammatory cysts were essential for evaluation. The effect of therapy was judged by changes in these lesions. The weather was cool to cold so thermal sweating was minimal. No patient was undertaking sufficient physical exertion to produce sweating. The regimen had to be followed for three months in order to allow an ample observation period. At first biweekly visits were required, then weekly, followed by 10 day to two week intervals.

A low sodium diet was prescribed and instructions were given where to obtain foods prepared without salt. Cleansing habits were not changed nor were cosmetics. The use of any topical proprietary product was discouraged. The urinary chloride was determined at the initial visit and each subsequent visit. The results were mentioned to the patient if requested, but the real purpose of the tests was to ascertain how carefully the diet was being followed, the level of urinary chloride reached and what effect this level had on acute lesions. Comments about improvement were left up to the patient.

### Case Reports

*Case #1.* A housewife, 24, had had a mild acne for some 10 years. An acute exacerbation developed late in the summer of 1964. The right forehead and preauricular areas showed closely packed clusters of deep-seated, bulbous pustules with halos of erythema. Below the mandibles was a 3-cm band of bright erythema packed with cone-shaped pustules; some of which were crusted. Others oozed a blood-tinged serum. The most severe involvement extended from each ala around the mouth to the submental region. Here there was a merging of inflammatory cysts about 1 cm and white cysts 2 to 3 mm in diameter with pustules crowded in between. She described the lesions as tender and sensitive. The uninvolved skin showed a greasy pallor and a faint melanosis. This patient was a "nibbler." She prepared but one meal a day because her husband worked nights. The rest of her calories came from snacks — bread, crackers, cheese spreads, lunch meats and soft drinks.

The urinary chloride was 18 gm/L. Five days later, it was 2 gm/L, and it remained in the 2-4 gm/L range for three months.

The first change appeared in two weeks. The uninvolved skin lost its pallor and discoloration. The complexion brightened. The forehead was free of lesions in three weeks, and the following week—at the end of one month—the preauricular regions cleared. During the next two weeks, the mandibular and chin regions underwent healing. Toward the end of two months, all acute lesions had disappeared. The desire to touch and fondle the lesions was gone. The patient noted the progressive improvement and discussed freely the changes in her dietary habits. She learned to like vegetables and fruit.

*Case #2.* A schoolgirl, 17, had had a bad complexion for several years, but during the

past three months, it had grown steadily worse. The cheeks showed a close outcropping of thin-walled pustules in various stages of activity. A greyish pallor affected the uninvolved skin.

The urinary chloride at her initial visit was 16 gm/L. She was asked to keep a food diary for one week to check out the source of salt intake. The chloride by then had increased to 18 gm/L. A low sodium diet was prescribed along with supplemental instructions. The following week the chloride was 8 gm/L and it stayed at this level or lower for a period of 10 weeks.

Little improvement was noted until three weeks had passed. The pustules gradually reduced in number and activity. At the end of five weeks, an excellent result was recorded which was maintained until discharge six weeks later. A final comment revealed how much this girl was impressed by the result, "My snacking days are over."

*Case #3.* A schoolboy, 14, had had pimples and blackheads for a year. During a two-month period, a progressive and acute flare-up occurred. The lateral aspects of the back of the neck, extending into the occipital region, showed a massing together of cone-shaped pustules in a band of bright erythema. Many of them were oozing. A less intense involvement affected the mandibular regions. The chin was covered by erupting, inflammatory cysts and pustules. The mid-forehead and lateral aspect of the nose and cheeks displayed patches of closely-packed comedones. The involved areas were sensitive and tended to sting. There was sufficient drainage from the neck lesions to soil clothing and bed linen.

The urinary chloride was 19 gm/L at the start of the low sodium diet. Bad weather prevented the next visit. Two weeks later, the urinary chloride was 2 gm/L. The mother was pleased with less soiled linen. Many of the pustules and cysts had flattened to dells of bright erythema. Some crusting of the sites was present. At the end of three weeks, the urinary chloride was still 2 gm/L, and it did not go above three for a period of two months.

The majority of the acute lesions disappeared in one month. A few comedones were still present on the forehead and nose at the end of two months. The mother was convinced as to why the improvement had occurred and was delighted to be rid of the extra laundry chores. The patient believed nightly bowls of salty popcorn accounted for the acute flare-up.

*Case #4.* A male college student, 18, had had acne for six years and was classed grade IV. The face, neck, and back displayed a fire-red, urticarial-like erythema. The inflammatory cysts were so numerous that they gave these regions a cobblestone outline. The scarring was extensive and deep. The chest had a pallor and was dotted by deep dells of erythema, the sites of previously drained cysts. Crusted and oozing ulcers 1-2 cm in diameter were present; one over the lower sternum, one on the back of the neck, two on the left shoulder and one on the right shoulder, drainage from these ulcers soiled his clothing and bed linen.

The urinary chloride was 16 gm/L. A low sodium diet was prescribed but with misgivings because this patient was required to eat in the college cafeteria five days a week. The urinary chloride ranged from 6 to 8 gm/L during the next four weeks. Eating at home over the holiday season brought it down to 3 to 5 gm/L, and by eating in his room at college, it was possible for him to keep it in this range for two months.

At the end of three months, he was better but far from well. All the ulcers had healed in three to six weeks. The cysts on the face and neck had disappeared, but new ones would crop up here and there. There might have been some reduction in the number of cysts on the back. The erythema had receded to a considerable degree. The patient and his mother were pleased with the results. To them, being rid of the ulcers was an achievement; moreover, no new ones had appeared. They also noted that there had been sufficient improvement to cause college friends to comment favorably. He desired to continue the regimen beyond the three-month period.

## Discussion

The initial experience with the patient who proved the incentive for this study impressed me to such an extent that I, too, tried a low salt diet. For some 15 years, I had had a chronic folliculitis over the back

of the neck. The lesions were sensitive and there was a desire to touch and press the acute ones. At times they caused comments by the barber and, occasionally, a patient was seen stealing a glance. One month on a low salt diet brought about an involution. There has not been a recurrence in six months and the desire to touch the area has disappeared.

I was a heavy salt user. A urinary chloride level of 1 to 2 gm/L was easily maintained. A complete taste adjustment has occurred; unsalted food has become as palatable as salted food.

The findings of the effect of salt intake in acne vulgaris in this study are presented as a mere probing of a difficult field known for its diverse therapies and strong clinical beliefs. Facilities are not available to carry out highly supervised low sodium regimens in a significant group of subjects with detailed quantitative studies on sodium and chloride. Observations admittedly only tentative, thus far suggest that the pallor, comedones and white cysts may be due to excessive dietary sodium, and the inflammatory reaction such as erythema, pustules, cysts, ulcers, and urticarial-like nodules may be due to tissue chloride overloading.

Estrogens and adrogens in stimulating the pubertal development of pilosebaceous structures also exert an influence on salt metabolism. This is especially true for estrogen. A dietary imbalance during this critical developmental period might easily and adversely affect hormonal adjustment as well as the disposition of these nutrients. This affliction of the adolescent might lead to the establishment of dietary allowances for sodium and chloride.

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## U. K. Drug Research Decreasing

"Research in the United Kingdom pharmaceutical industry, which has been increasing at 20% a year in the five years beginning in 1956, has now slowed down. The main reason is the unsatisfactory state of patent law and practice, especially the regulation that allows a company to apply at any time for a compulsory license from a firm which may have spent large sums of money to develop a particular drug."—*Financial Times* of London, January 13, 1965.

# Comparative Efficacy of Mebutamate Combined with Hydrochlorothiazide in Essential Hypertension

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HYPERTENSIVE PATIENTS, as a rule, respond with additional increases in blood pressure when confronted with an emotional stress situation. Until the advent of hypotensive drugs, the accepted course for control of hypertension consisted of the physicians' advice that patients attempt to control their emotions. Therapy included the prescription of a mild sedative to reduce the response to tension-provoking stimuli and dietary restrictions upon the patient's salt intake.

Recently the treatment of essential hypertension has been modified by the availability of thiazide diuretics and mebutamate*,[1] a new hypotensive drug indicated for mild to moderate grades of this condition.

In previous studies,[2,3] a combination of mebutamate and hydrochlorothiazide† was effective in lowering the blood pressure in hypertensive patients.

## Method

The purpose of this study was to determine whether a combination of mebutamate (150 mg.) and hydrochlorothiazide (12.5 mg.) is more effective than hydrochlorothiazide (12.5 mg.) alone in the treatment of patients with mild to moderate hypertension.

This study began with 19 office patients. In order to establish a true baseline pressure, all antihypertensive medication was discontinued.

The study was conducted on a single-blind basis, that is the tablets were so formulated that patients could not distinguish between hydrochlorothiazide alone and the combination. When it was felt that stable blood pressure levels had been attained, all patients were started on the mebutamate-hydrochlorothiazide combination tablet.

Four patients received this drug throughout the course of the study, seven subsequently were alternated weekly between the combination agent and hydrochlorothiazide alone, and the remaining patients also alternated between the two drugs, but not in any particular design or sequence. The average duration of treatment was six months for the period in which only the combination was administered and two months in which the two agents were alternated in weekly sequence. Blood pressure readings, recorded at each visit, were taken from the arm with the patient in a sitting position.

As with other antihypertensive agents, the dose of mebutamate and hydrochlorothiazide combined had to be adjusted to the individual patient. Some patients were normotensive on two tablets per day, while others required as many as eight tablets. However, most patients did very well on four tablets per day (total daily dose: 600 mg. mebutamate + 50 mg. hydrochlorothiazide). The drug was taken 30 minutes before meals and at bedtime when necessary.

## Results

The results of this study, given in Tables 1 and 2, enable a comparison to be made of the effectiveness of the two agents in cases of mild and moderate hypertension. Pretherapy systolic pressure ranged from 150 to 250 mm. Hg, with an average of 192.3 mm. Hg; diastolic pressure ranged from 86 to 130 mm. Hg, with an average pressure of 109 mm. Hg.

After administration of Caplaril, the average systolic pressure dropped to 154.7

* Capla®, Wallace Laboratories

† Caplaril T.M., Wallace Laboratories

mm. Hg — a decrease of 37.6 mm. Hg — while the diastolic pressure dropped from a pretherapy average of 109 mm. Hg to 92.8 — a decrease of 16.2 mm. Hg. The respective decreases for patients on hydrochlorothiazide were 28.3 mm. Hg systolic and 10.1 mm. Hg diastolic (Table 1). Changes in mean arterial pressure are also shown in Table 1.

Statistical analysis indicated that the difference in responses to the two agents was highly significant, within a confidence level of over 99% (Table 2). In addition to the effective lowering of blood pressure, patients receiving the combination drug frequently were observed to have become calmer and more relaxed. One-third of the patients stated that they felt better while they were receiving combined therapy; this type of response was not forthcoming from the patients while they were on hydrochlorothiazide alone.

Other than complaints of slight, transient dizziness in three patients, there were no signs of adverse effects in the 17 patients who completed this study. Two of the original 19 patients were dropped soon after the study began because their pressure could be controlled only on doses twice as great as the maximum employed for any of the other patients. At these levels, drowsiness became a problem and suggested discontinuation of the drug in these two patients.

The results indicate that mebutamate with hydrochlorothiazide provided better control in mild to moderate hypertension than did hydrochlorothiazide alone. The combination seems preferable to a regimen of hydrochlorothiazide with phenobarbital added, because the mebutamate component of the new drug exerts an independent hypotensive effect which we have not observed when phenobarbital has been used.

## Discussion

These results confirm reports in the literature[4-8] that mebutamate is effective in the treatment of mildly to moderately hypertensive patients. Theoretically, mebutamate should be of value in the long-term treatment of hypertension because of its favorable influence upon the vasomotor

COMPARATIVE EFFECTS OF CAPLARIL AND HYDROCHLOROTHIAZIDE ON BLOOD PRESSURE

| Patient | Pretherapy | | Caplaril Therapy | | | | Hydrochlorothiazide Therapy | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Average * | | Change † | | Average * | | Change † | |
| | S/D | MAP | S/D | MAP | S/D | MAP | S/D | MAP | S/D | Map |
| 1 | 150/100 | 117 | 147/87 | 107 | 3/13 | 10 | 174/90 | 118 | +24/10 | +1 |
| 2 | 200/100 | 133 | 161/80 | 107 | 39/20 | 26 | 165/90 | 115 | 35/18 | 18 |
| 3 | 152/86 | 108 | 153/94 | 113 | +1/+8 | +5 | 158/91 | 113 | +6/+5 | +5 |
| 4 | 165/110 | 128 | 159/100 | 120 | 6/10 | 8 | 163/103 | 123 | 2/7 | 5 |
| 5 | 160/106 | 124 | 136/95 | 109 | 24/11 | 15 | 143/99 | 114 | 17/7 | 10 |
| 6 | 220/120 | 153 | 190/12 | 138 | 30/8 | 15 | 202/120 | 147 | 18/0 | 6 |
| 7 | 190/110 | 137 | 167/107 | 127 | 23/3 | 10 | 173/107 | 129 | 19/3 | 8 |
| 8 | 180/108 | 132 | 146/95 | 112 | 34/13 | 20 | 155/100 | 118 | 25/8 | 14 |
| 9 | 220/130 | 160 | 142/94 | 110 | 78/36 | 50 | 158/100 | 119 | 62/30 | 41 |
| 10 | 194/104 | 134 | 147/88 | 108 | 47/16 | 26 | 160/90 | 113 | 34/14 | 21 |
| 11 | 178/108 | 131 | 154/105 | 121 | 24/3 | 10 | 160/107 | 125 | 18/1 | 6 |
| 12 | 250/130 | 170 | 159/94 | 116 | 91/36 | 54 | 164/102 | 123 | 86/28 | 47 |
| 13 | 204/104 | 137 | 145/82 | 103 | 59/22 | 34 | 158/87 | 111 | 46/17 | 26 |
| 14 | 190/100 | 137 | 158/89 | 111 | 32/21 | 26 | ..... | ..... | ..... | .... |
| 15 | 198/100 | 133 | 166/95 | 119 | 32/5 | 14 | ..... | ..... | ..... | .... |
| 16 | 210/116 | 147 | 148/90 | 109 | 62/26 | 38 | ..... | ..... | ..... | .... |
| 17 | 210/112 | 145 | 153/75 | 100 | 57/37 | 45 | ..... | ..... | ..... | .... |
| TOTALS | 192.4 / 109.1 | 136.8 | 154.8 / 93.1 | 113.5 | 37.6 / 16.0 | 23.3 | 164.1 / 98.9 | 120.6 | 25.4 / 10.6 | 15.2 |

TABLE 1

S=Systolic
D=Diastolic
MAP=Mean Arterial Pressure

* Based on at least three readings at each visit.
† Decrease, except where noted.

STATISTICAL ANALYSIS OF 13 PATIENTS RECEIVING BOTH DRUGS

| | Caplaril | | | Hydrochlorothiazide | | | Paired Differences | | |
|---|---|---|---|---|---|---|---|---|---|
| | S | D | MAP | S | D | MAP | S | D | MAP |
| Minimum | 136 | 80 | 103 | 155 | 87 | 111 | 4 | −2 | 0 |
| Maximum | 190 | 112 | 138 | 202 | 120 | 147 | 24 | 10 | 11 |
| Average | 154.3 | 94.7 | 114.7 | 164.1 | 98.9 | 120.6 | 9.54 | 4.15 | 5.92 |
| St. Dev. | 13.77 | ..... | 9.44 | 13.81 | 9.34 | 9.56 | 5.88 | 2.8 | 3.15 |
| "t" | ..... | ..... | ..... | ..... | ..... | ..... | 5.85 | 5.34 | 6.78 |
| p | ..... | ..... | ..... | ..... | ..... | ..... | 0.01 | 0.01 | 0.01 |

S=Systolic
D=Diastolic
MAP=Mean Arterial Pressure

center. A hyperactive vasomotor center often is associated with elevated blood pressure, which if sustained, leads to pathological changes in the arteries, heart, kidney and brain. Thus treatment of mild hypertension on the basis of immediate symptoms is highly desirable, since prophylaxis may prevent the degeneration of organs that is concomitant with sustained hypertension.

The presence of hydrochlorothiazide in this compound reinforces the attack on the hypertension profile. It is especially valuable alone when elevated systolic and diastolic blood pressures are accompanied by fluid retention and obesity. Borhani,[9] Calesnick[10] and Schwartz et al.[11] have reported on its favorable effects in patients presenting this triad.

Thus these drugs, while effective when used separately in selected cases, appear to be more effective when administered simultaneously in a single tablet. This study has shown that Caplaril reduces systolic and diastolic levels to a point beyond that achieved by hydrochlorothiazide alone; but the feeling of well-being of patients treated with this drug went beyond that to be expected solely from reduction of blood pressure.

The calmness and reduction in hyperemotionality — presumably a result of the influence of the mebutamate component[8,12] — is an important feature of the total therapy and augments the value of this agent in the treatment of mildly hypertensive individuals. Although objection to combinations is sometimes voiced on the grounds of difficulty in dosage adjustment, the individual strength of the drugs in this particular compound seem well suited to physicians' needs.

## Summary


1. Seventeen patients suffering from mild to moderate hypertension were treated with a compound containing mebutamate 150 mg. plus hydrochlorothiazide 12.5 mg. in dosage schedules ranging from two to eight tablets per day for periods up to 14 months (average: six months).

2. The blood pressure of these patients was reduced from an average pretherapy level of 192.3/109 (range 150-250/86-130) to an average of 154.7/92.8 (range 136-190/74-112).

3. Thirteen of the 17 patients were alternated between the combination and hydrochlorothiazide alone for periods averaging two months. The average blood pressure of the patients treated with the combination was 154.3/94.7 mm. Hg, compared to an average blood pressure of 164/98.9 mm. Hg when hydrochlorothiazide was given exclusively.

4. The superiority of Caplaril over hydrochlorothiazide alone was statistically highly significant.

5. Adequate blood pressure response in two patients could be obtained only with doses that induced drowsiness, therefore they were dropped from this study. Slight, transient dizziness in three patients was the only other complaint.

6. One-third of the patients experienced a feeling of well-being while on combination therapy, but not on hydrochlorothiazide alone.

7. Mebutamate, because of its mild sedative action as well as its ability to reduce the activity of the vasomotor center, is a

satisfactory therapeutic agent for early hypertension. On theoretical grounds, it may prevent progressive degenerative changes associated with increasingly severe forms of this disease.

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## Special Mission of Drug Makers

The manufacturer of a drug has a special mission in life if his goal is progress and growth and public contribution. He must depend on research even more than promotion if he is to achieve this goal and hold it. For without this exploring of the unknown he can be certain that to mark time is an act designed for those who are suicidally minded businesswise. His is a trust shared by the professional man looking for new ways to heal ailing bodies, by those on whose bodies the healing will occur, and by the investing public as it puts to work its available cash to help this part of our life grow. —Austin Smith, M.D., in *Experimental Medicine and Surgery,* 22:2-3, (June-Sept.) 1964.

# Bacterial Contamination in Acute Traumatic Wounds Treated in Office Practice

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THIS STUDY was undertaken to determine the adequacy of surgical preparation of acute traumatic wounds treated in the average general practitioner's office.

Since the majority of traumatic wounds sutured primarily under local anesthesia in a physician's office are considered "minor" wounds, it is possible that "minor" preparation might also be given them on occasions. Subsequent infections occurring in these so-called minor wounds are known to result occasionally in complications of major proportions.

Cultures were obtained from patients with acute traumatic wounds severe enough to require suturing, who were treated in an out-patient clinic. The individuals in the study were of all age groups from pediatric to adult and all lacerations were treated within one hour from the time of injury.

## Materials and Methods

Several physicians treated the patients included in this study and each physician was the sole judge of the adequacy of wound preparation prior to skin closure. The lacerations were all surgically scrubbed either by the physician or his assistant according to his usual routine. No special clinic instructions were given as to the materials to be used for the skin and wound cleansing prior to suturing or to the time spent in accomplishing the cleansing. In most instances, however, surgical soap and water constituted the materials. Unfortunately, as we shall see later, wound irrigation with sterile water or sterile saline solution was rarely carried out. Sterile gloves were worn by all physicians but no gowns or masks were used.

Wounds were anesthetized with a local anesthetic of the physician's choice and the majority were injected through the gaping wound edges. In six cases however, the physician injected the anesthetic through the intact skin around the wound. Debridement, where indicated, and suturing were carried out in all cases by the physician in his usual manner. Patients to whom the attending physician administered "routine" antibiotics were not included in this study.

Cultures were taken with sterile swabs from the skin adjacent to the wound and from the wound itself, both before and after the wound had been prepared for primary suturing. The swabs were then dropped into thioglycollate broth and cultures showing bacterial growth after incubation were plated on blood agar and other media to derive a definitive bacterial classification.

Follow-up care was given by the physician attending each case and a record was kept to indicate whether the wound healed per primam or developed infection. Unfortunately no follow-up cultures were obtained of the four wounds which did develop infection to determine if the bacteria were the same as those recovered from the wound prior to closure.

Table 1 summarizes the findings of this study. Thirty-three wounds were studied. Bacteria were recovered from the unprepared skin in all cases and after skin preparation in 19 cases. The unprepared wound harbored bacteria in 24 instances and still did in 20 cases after the wound was cleansed. The specific bacteria recovered are listed.

## Discussion

Many of the bacteria recovered were those generally listed as normal skin inhabitants[1] and non-pathogenic, however commensals often become opportunists when the skin is injured. Pathogenic bacteria were also isolated from both skin and wound cultures and the high recovery rate of bacteria from "clean" wounds in this study is disconcerting.

In a similar study where wound preparation procedures were standardized and a

RESULTS OF CULTURES ON 33 WOUNDS

| | Before Skin Preparation | After Skin Preparation | Before Wound Preparation | After Wound Preparation |
|---|---|---|---|---|
| Number of Cultures Showing Bacterial Growth | 33 | 19 | 24 | 20 |
| S. Aureus Coagulase Positive | 10 | 5 | 4 | 6 |
| Alpha Hemolytic Streptococci | 3 | 0 | 4 | 2 |
| S. Albus Coagulase Negative | 4 | 1 | 3 | 2 |
| Aerobacter Aerogenes | 4 | 3 | 5 | 3 |
| Gamma Streptococci | 0 | 0 | 1 | 1 |
| E. Coli | 1 | 2 | 2 | 1 |
| S. Epidermidis | 8 | 10 | 5 | 6 |
| B. Subtilis | 9 | 4 | 6 | 3 |
| Pseudomonas (unidentified) | 0 | 0 | 1 | 0 |

TABLE 1

copious saline wound irrigation was utilized, 16 of 20 wounds showed no bacterial growth prior to closure.[2]

Although bacteria were recovered easily from the wounds in this study, 29 of 33 wounds still healed per primam. This only substantiates our knowledge that factors other than the presence of bacteria are important in wound healing. There was no indication that injection of local anesthetics through the wound edges contributed in any way to a higher infection rate as 24 of the 33 wounds were anesthetized in this manner.

Certainly no profound conclusions can be drawn from such a small series. Yet the indications seem clear that in dealing with an ever-increasing patient load, we must not slight the basic principles of good wound care.

A more thorough cleansing of lacerations and increased use of irrigation technics is as necessary for the so called "minor" wounds treated in office practice as for those wounds treated in the surgical suite.

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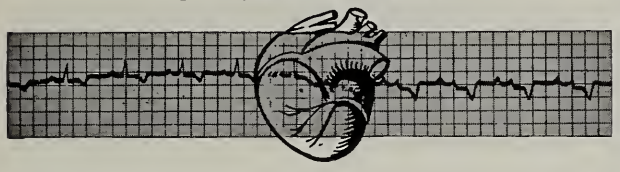
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## Many Many Man Hours

The time spent on developing just one new, efficient drug product—if only one person were involved in all the study and research—would require 19 working years—or 58,000 hours—of a research chemist's life.

# Electrocardiogram
## of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Nonparoxysmal A-V Nodal Tachycardia with QRS Alternans Due to Digitalis*

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THE APPEARANCE of a regular rhythm in patients treated with digitalis may on rare occasions be due to reversion to normal sinus rhythm. Most often however it heralds the onset of (1) complete heart block if the rate is slow and regular or (2) A-V nodal tachycardia if the rate is rapid and regular. The latter indicates a high degree of digitalis intoxication and unless the drug is discontinued, nearly all of the patients will die.

Electrical alternans is most often seen in pericardial effusion with tamponade. It has been occasionally described in other conditions, such as severe heart disease and particularly digitalis intoxication.

The tracing show in Figure 1, recorded on a 83-year-old man, is an example of atrial fibrillation, A-V nodal tachycardia and electrical alternans of the QRS. The tracing recorded on March 3, 1965 shows simple atrial fibrillation, with absence of P waves, irregular wavy baseline ("f" waves), irregular ventricular response and occasional ventricular premature systoles.

On March 12, 1965, after a total of 3.0 mg of digitoxin was administered, the tracing showed a perfectly regular QRS rate of about 160. The baseline is still wavy with occasional "f" waves present indicating atrial fibrillation. The regularity of the QRS and the fact the duration is normal, indicates origin above the bifurcation of the bundle of His, namely in the A-V node. The electrical alternans is manifested by alternate variation in the amplitude of the QRS.

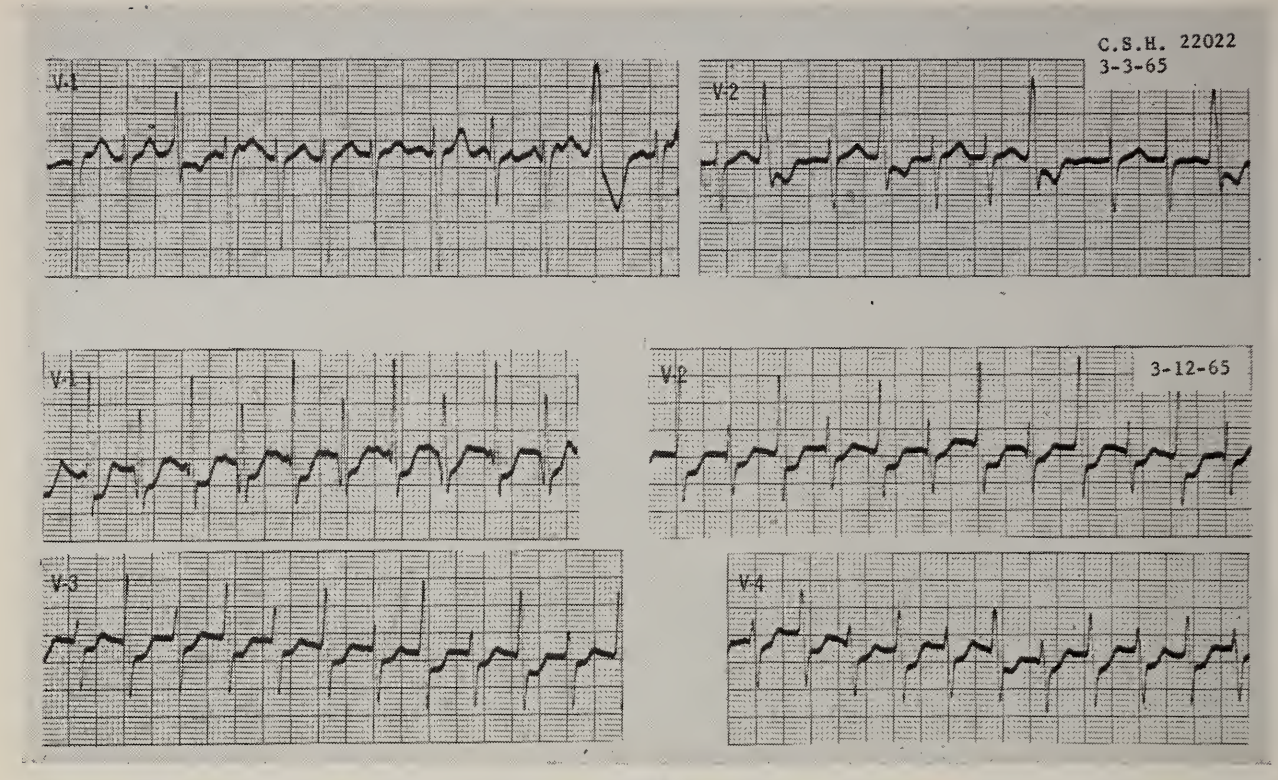



**FIGURE 1**

**TRACING taken on 3-3-65 shows atrial fibrillation with occasional ventricular premature systole. The ECG recorded on 3-12-65 shows nonparoxysmal A-V nodal tachycardia with electrical alternans of the QRS.**

## Drugs and the Changing Causes of Death

Man's progress in the field of medicine over the last half century has been phenomenal, and the pharmaceutical industry is proud of the part that it has played. It is only necessary to reflect on the significant changes that have come about in the relative position of the leading causes of death at the beginning of that period. Accidents were twenty-eighth on the list of causes of death and now are fourth. Accidents today constitute the leading cause of death among children five to fifteen years of age, whereas rheumatic fever occupied this position fifteen or twenty years ago. Tuberculosis, once "the captain of the men of death," is now seventeenth on the list and will go lower.—Alfred E. Driscoll, President, Warner-Lambert Pharmaceutical Company, in *New England Journal of Medicine,* 270:6, (Feb. 6) 1964.

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Current Concepts of Selective Radiotherapy and Chemotherapy in the Treatment of Tumors of the Genitourinary Tract*

ERICH K. LANG, M.D.†
*Indianapolis*

THIS 38-year-old white male patient illustrates the role of modern chemotherapy and selective radiotherapy in the treatment of cancer of the genitourinary tract.

The patient was admitted to this hospital some four and one-half years ago for hematuria. Intravenous pyelograms revealed a mass lesion in the right kidney, resulting in considerable tilt of the kidney axis. A hypernephroma was suspected. Exploration confirmed the diagnosis and the right kidney was removed. At the time of this transabdominal exploration, metastases to the left kidney were noted and there was a mass in the left suprarenal gland. External radiotherapy appeared to be contraindicated since we were dealing with a single remaining kidney.

The patient was given a chemotherapeutic agent, Velban (vinblastine sulfate), for the following two years. Several arteriograms were performed, demonstrating progressive but slow growth of the metastases in the left kidney and the suprarenal gland.

### Materials and Methods

During the past year, selective arterial perfusion with another chemotherapeutic agent has been employed (nitrogen mustard). Proper placement of the selective arterial catheter into the orifice of the artery supplying the tumor is monitored fluoroscopically. One to three milligrams of nitrogen mustard are slowly infused through this end-hole catheter. The patient withstood the procedures without untoward effects.

A restudy, performed some four months later, revealed large areas of necrosis and puddling of dye in the previously described tumor mass in the suprarenal gland. The arterial supply pattern of this particular patient, with a separate artery supplying the suprarenal area, a separate artery supplying the anterior and posterior upper two-thirds of the left kidney and a separate artery supplying the lower pole of the left kidney, permitted selective perfusion of each of these segments. The presence of the lower polar artery guaranteed adequate functional renal tissue in case of a renal shutdown following perfusion of the midsegment of the kidney with cytotoxic agents.

During the ensuing 10 months, the patient was subjected to three selective perfusions with nitrogen mustard, of either the suprarenal artery or the posterior branch vessel supplying the upper two-thirds of the kidney harboring the large intrarenal metastases. The last arteriogram revealed significant and definite regression and necrosis of the tumor in the suprarenal gland and better demarcation of the me-

* Supported by a grant of the Indiana Cancer Society.

† Radiologist, Methodist Hospital.



FIGURE I

THE selective arterial injection phase of the left renal artery supplying the midportion of the left kidney demonstrates a huge metastases in the midsegment of the left kidney. Several branch vessels supply the tumor tissue in the area of the suprarenal gland. The tumor, supplied by a separate artery, has apparently tapped into the vascular supply of the kidney.



FIGURE II

AN 11-SECOND delayed stain phase film demonstrates multiple, well-circumscribed nodular tumor implants in the midportion of the left kidney and in the area of the suprarenal gland.

tastatic lesion in the kidney. A change of the vascular pattern of the intrarenal metastases was felt to be secondary to progressive fibrosis. The general condition of the patient showed progressive improvement, he gained 15 pounds and was able to pursue gainful employment throughout this period interrupted by hospitalizations of only 17 days. His blood urea nitrogen never exceeded a value of 18 milligram percent, his hemoglobin fluctuated between 10.4 and 14.2 grams.

## Discussion

In view of the gratifying response of hypernephroma metastases to selective perfusion with nitrogen mustard, other patients with a diagnosis of hypernephroma were subjected to a similar treatment. Nitrogen mustard, although not the most desirable chemotherapeutic agent for the treatment of genitourinary tumors, was chosen because of its property of being inactivated by the first tissue barrier. An elongated and flanged catheter was deeply inserted into the supply vessel, the injection was carried out slowly to prevent reflux of the toxic material into the aorta or other branch vessels originating from a common trunk at a more proximal position.

Two other hypernephromas were treated with a single dose of one to four milligrams of nitrogen mustard, following arteriographic identification of the tumor and its supply. The patients were operated upon 11 to 32 days after nitrogen mustard perfusion. In each instance, a definite decrease of the size of the tumor mass could be ascertained. The most striking example showed a decrease of the long axis of the kidney by 4cms. (from 19 to 15cms.) of the short axis at the most prominent tumor protuberance by 3cms. (from 10 to 7cms.). Preoperative nitrogen mustard perfusion did not complicate operative removal.

In the recent past, selective radiation therapy to such tumors has become a reality. Selective engagement of the supply artery allows infusion of small radioactive particles, which will ultimately infarct the peripheral arterial and capillary bed of such a tumor. The size of these particles is critical to insure infarction of the arterioles and capillaries of the tumor and prevent passage of these particles into the systemic circulation through arteriovenous tumor

shunts. Proper infarction of a tumor with these small clay microspheres, loaded with a Beta emitter, assures homogeneous irradiation of the entire area. The use of Beta emitters offers advantageous selective tumor irradiation because of complete absorption of the radiant energy within the tumor, and avoids the huge integral dose to normal tissue complicating the various modalities of external radiotherapy. A more intensive treatment of the tumor itself with less systemic effects can thus be guaranteed.

This new approach in the management of genitourinary tumors appears to show great promise. The entire battery of chemotherapeutic agents, however, deserves adequate trial for final selection of the most appropriate substance. No claim is made that an adequate assessment of other chemotherapeutic agents has thus far been carried out. ◄

## From *The Journal* 50 Years Ago

. . . I have used subconjunctival injections of mercury for a long time, But I have never used them in incipient cataract and I do not think I ever shall. I think the essayist is to be commended for having had the courage to try such a heroic treatment in this class of cases. We must remember that Colonel Smith has been using his treatment in a far different class of cases from those we see in this country. Those people in India, with their stoic dispositions, their ability to stand pain, their early development of cataract at the time when their physical condition is much better than in advanced age, are very different from the cases we have to deal with here, and all those things must be taken into consideration when we estimate the value of the treatment.

* * * * *

I would fear to use the treatment on patients whose physical condition at 60 or 70 is not of the best. There are very few who are advocating this particular form of treatment. There are those, however, who have advocated the subconjunctival injections of dionin, which to my notion, from a physiologic point of view, is much more applicable in the treatment of these cases than is the injection of mercury. I have used dionin with a fair degree of success and you will notice that the essayist in practically all of his cases is using dionin also, not subconjunctivally, perhaps, but locally, and we know that dionin has a favorable effect on the nutrition of the lens through lymphagogue action.—Dr. Albert E. Bulson discussing "The Treatment of Incipient Cataract with Subconjunctival Injections of Cyanid of Mercury" by A. B. Knapp, M.D., *JISMA*, August, 1915.

# LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

# Radioisotope Scanning

WEI-PING LOH, M.D.*
Gary

RADIOISOTOPE scanning, begun in 1950, has made rapid progress in the last few years. This procedure provides visualization of an internal organ by determining the spatial distribution of a radioisotope within the body. Satisfactory visualization is primarily dependent upon the selective deposition of gamma-emitting radioisotopes in specific organs.

It is not necessary to achieve high concentration of the radioisotope in a specific organ. The relative concentration of the radioisotope in the organ with respect to its surroundings is the important criterion rather than the absolute concentration. This paper summarizes the current uses of this valuable procedure. The technical details and the physics involved will not be discussed.

### Thyroid Scan

Thyroid scan is the oldest technic in radioisotope scanning. This procedure using 131-I or 125-I has the following uses:

1. Accurate estimation of the thyroid size in addition to radioisotope uptake of the thyroid.
2. Detection and localization of functioning thyroid tissue outside of the normal location, such as location and estimation of the size of a substernal thyroid.
3. Localization and estimation of the size of a thyroid nodule. The nodule may not be accurately studied unless its size is one cm. or larger.
4. Estimation of the functioning activity of the thyroid nodule. Twenty-five percent of the patients with solitary cold (underactive) nodules will be found to have thyroid carcinoma.
5. Detection and localization of residual thyroid tissue following a "total thyroidectomy" as a standard surgical procedure for thyroid carcinoma. This scanning procedure is generally performed three weeks post-surgery. All remaining thyroid tissue detected by this procedure may be ablated with 131-I, and the patient placed on a maintenance thyroid therapy.

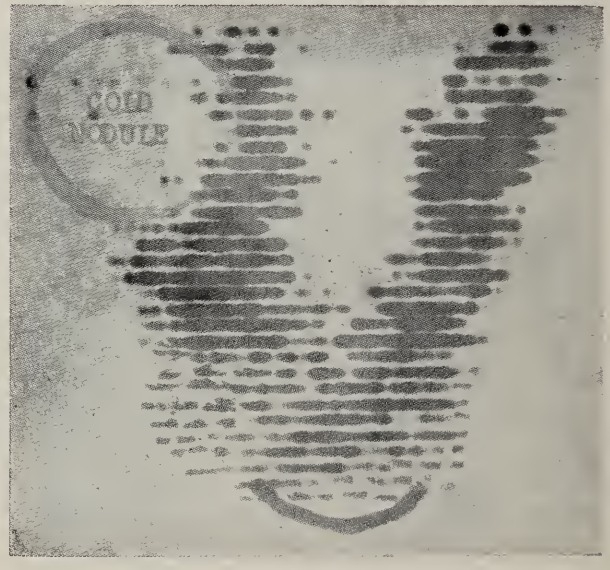



FIGURE 1
THYROID scan using 1-131. Notice a solitary cold nodule in the right upper field (a carcinoma).

* Chief Pathologist, Methodist Hospital of Gary, Inc.; Asst. Professor of Pathology, Chicago Medical School.

6. Detection and estimation of the radioisotope uptake of the metastatic thyroid carcinoma tissue. This information is needed for treatment of the metastatic disease.
7. Follow-up of the post-surgery patients at yearly intervals.
8. Suppression scan and stimulation scan designed to study functional control of the thyroid.

### Brain Scan

Brain scan has become the screening technic of choice for the localization of space-occupying lesions of the brain. In a study of 1,500 cases, the general accuracy of the brain scan was reported to be 96-98%. This procedure should be done before the arteriogram as the brain scan will be abnormal for 48 to 72 hours after carotid arteriography. We generally use mercury-labeled Neohydrin which is concentrated in the carcinomatous cells as well as in the hemorrhagic or infarcted areas. This procedure has the following applications:

1. Detection and localization of subdural hematomas.
2. Detection and localization of aneurysms, A-V malformations and other vascular abnormalities. The detection of all these conditions requires an early scanning, and the result is at least as good as, or even better than that of an arteriogram. It is certainly better than the results of other x-ray procedures.
3. Detection and localization of non-calcified meningiomas. A 100% accuracy has been claimed in the detection of this tumor.
4. Localization of metastatic carcinomas and astrocytomas (especially malignant astrocytomas) and the differentiation between these tumors and the vascular lesions. In these cases, the five hour repeat scan will still be positive in the majority of malignant tumors.
5. Detection and localization of cerebral infarcts. In these cases, the scan usually becomes negative or returns to normal within one to three months.
6. Evaluation of subtentorial lesions, using a reverse Towne's position, and the localization of deep tumors.

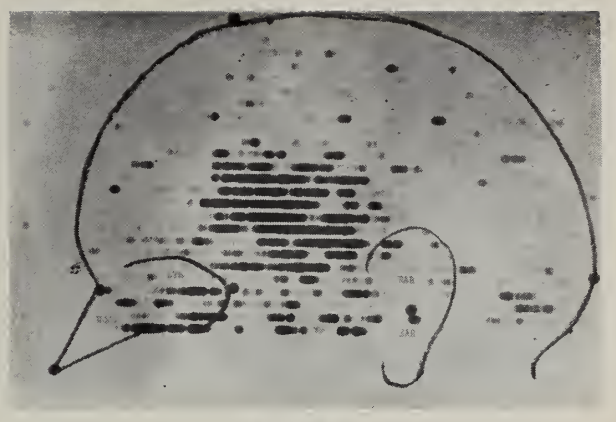


FIGURE II
BRAIN SCAN using Hg-203 Neohydrin. The dark area at the left sphenoid area proved to be a meningioma.

### Renal Scan

Renal scan is a useful tool in the evaluation of renal diseases, and is frequently used in conjunction with the x-ray contrast studies and renogram. This procedure using mercury-labeled Neohydrin has the following uses:

1. Determination of renal size and space-occupying lesions in the kidneys.
2. Detection of anatomical anomalies, such as fetal lobulation, ectopia, agenesis, etc.
3. Demarcation for renal biopsy.
4. Separation of intrinsic mass from extrinsic mass. The radioisotope can penetrate into the renal parenchyma, whereas the contrast media in the x-ray studies are confined to blood vessels or normal spaces in the kidneys.
5. Detection of early polycystic disease of the kidneys. In this case, renal scan is much more accurate than any x-ray study.
6. Evaluation of renal vascular diseases and renal tuberculosis.
7. Procedure of choice when the patient is allergic to iodine-containing radioisotopes and iodinated contrast media used in x-ray studies.
8. The most sensitive test for the detection of small amounts of viable renal tissue.

### Liver Scan

A well done liver scan, utilizing 198-Au which concentrates in the reticuloendothelial system, offers the following useful information:

1. Accurate determination of the size, shape and position of the liver. The liver volume can be determined within a ± 10% error.
2. Detection and localization of primary or metastatic carcinoma with lesions as small as three cm. in size.
3. Delineation of space-occupying lesions, such as amoebic or post-surgical abscesses, hematomas, hemobilia and echinococcus cysts.
4. Differentiation between cirrhotic changes and severe multiple metastatic disease. The former will show splenic enlargement and concentration of the isotope in the spleen.
5. Evaluation of a gallbladder which cannot be visualized in x-ray studies.
6. Valuable in the differential diagnosis of obstructive jaundice. Rose bengal labeled with 131-I is used in this study.

**Cardiac And Vascular Scan**

A properly performed scan, utilizing RISA (radioactive iodinated serum albumin containing 131-I) and performed in conjuction with x-ray studies, offers the following useful information:

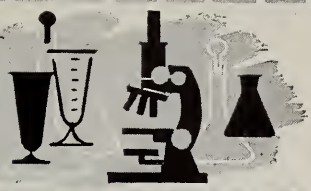
1. Detection and evaluation of pericardial effusion. The RISA remains in the heart chambers and does not enter the pericardial fluid.
2. Evaluation and differentiation between cardiac dilatation and cardiac hypertrophy. Detection of infarcts is still experimental.
3. Evaluation of a tumor or solid chest mass.
4. Detection of aneurysms of the myocardium, aorta and larger arteries.

**To be concluded next month.**

## In Praise of Drug Advertising

All studies show clearly that [pharmaceutical] advertising is effective and that it is useful. Information is sought by physicians from the detail man, from journal advertising, and from direct mail advertising, usually in that order. Occasional nuisance though it may seem to be . . . it is clear that pharmaceutical advertising is much too important to be ignored as a factor in progress.—H. L. Hartley, M.D., in *Northwest Medicine,* 64:1, (Jan.) 1965.

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



**This new series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It will be edited by Leon L. Blum, M.D., Terre Haute.**

# *Differential Diagnosis of the Month:* MACROCYTIC ANEMIA

*LEON L. BLUM, M.D.*
*Terre Haute*

| | |
|---|---|
| *Clinical data:* | A 59-year-old woman complained of increased fatigability, weakness of several months' duration and occasional rectal bleeding. |
| *Physical examination:* | Marked pallor, soft "hemic" murmur over precordium. External and internal hemorrhoids. No other significant findings. |
| *Laboratory data:* | Hb: 7.8 Gm (cyanmethemoglobin method), RBC (in mill.): 2.4 (electronic), 2.8 (photoelectric), WBC: 4,800, Hematocrit: 23, MCH: 35.7 micro-micrograms, MCV: 109 cu. microns, MCHC: 32.5%.<br>Blood Smear: Marked anisocytosis and poikilocytosis with many macrocytes. Slight hypersegmentation of polymorphonuclear leukocytes. Platelets slightly reduced. Differential count: Moderate lymphocytosis (42%). |
| *Consultation note:* | The pathologist was consulted because of unexplained anemia and advisability of blood transfusions. The hematologic indices and the fact that the uncorrected photoelectric red cell count was higher than the electronic count indicated a macrocytic deficiency type of anemia and not hypochromic post-hemorrhagic type. Accordingly, the use of blood was discouraged and additional laboratory tests recommended which gave the following results: Reticulocyte count: 2.7%, serum bilirubin: 1.3 mg., serum iron: 206 micrograms, gastric analysis with histalog: No free hydrochloric acid. Schilling test I: 2.7% of the dose of radioactive $B_{12}$ excreted. Schilling test II (with intrinsic factor): 11.5% of $B_{12}$ excreted. Serum iron after $B_{12}$ injection: 38 micrograms. |

| | |
|---|---|
| *Interpretation:* | The laboratory findings indicate that the macrocytic anemia was due to deficiency of the intrinsic factor and establish the diagnosis of "pernicious anemia." The drop of serum iron to normal level after injection of $B_{12}$ is characteristic of $B_{12}$ deficiency. The Schilling test (radioactive $B_{12}$ absorption test) is a specific procedure for differential diagnosis of macrocytic anemia when $B_{12}$ deficiency is suspected.<br>1) Urinary excretion of less than three percent of the dose is highly suggestive of pernicious anemia.<br>2) Excretion between 3-12% may indicate a partial deficiency of the intrinsic factor or intestinal malabsorption.<br>3) Excretion above 12% excludes deficiency of the intrinsic factor.<br>In case of low urinary excretion of $B_{12}$ full confirmation of the diagnosis requires a second test in which radioactive $B_{12}$ is given together with intrinsic factor (Schilling test II).<br>An increase of excretion in Schilling test II by at least 7-10% indicates a deficiency of intrinsic factor (pernicious anemia). No significant increase indicates malabsorption syndrome.<br>Bone marrow examination disclosing megaloblastic dyspoiesis cannot differentiate between deficiency of $B_{12}$ and other deficiencies, such as folic acid. Previous administration of $B_{12}$ may rapidly convert megaloblastic marrow to normoblastic but will not interfere with the results of the Schilling test. One of the sources of error in the Schilling test is impaired renal function with oliguria of cardiac or renal origin. If less than 1000 ml. of urine is excreted in 24 hours., urine should be also tested the following day. |
| *Follow-up:* | The patient was given $B_{12}$ with satisfactory reticulocyte response and hematologic remission in three weeks. Blood intended for transfusion remained in the blood bank for a patient needing it. |

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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# The G.P. and Occupational Health

ALMOST all physicians in Indiana are concerned with occupational health!

Most of us tend to think of occupational health in terms of huge industries such as steel, automotive, aircraft and the like but actually the vast majority of employees in Indiana and elsewhere work in small plants and small business establishments. Since very few of these thousands of small working units have organized in-plant medical services, the occupational health problems of their employees fall to the family physician. But orthopedic surgeons, internists, dermatologists, psychiatrists—just to name a few specialists—also deal increasingly with occupational health problems.

Orientation of any physician's thinking to the preventive philosophy of occupational medicine will enable him to do a better job of health maintenance of workers among his patients, as well as better handling of their Workmen's Compensation injuries.

Indiana physicians who are interested in serving their employee patients more adequately have an unusual opportunity to become better acquainted with the scope, objectives and functions of occupational health at the unusual joint meeting of the Indiana State Medical Association and the annual American Medical Association Congress on Occupational Health. This joint meeting, which is *your* annual meeting, will be held at the Murat Temple in Indianapolis, October 12-14 and will feature eminent speakers from Indiana, as well as from medical centers throughout the nation.

The program will feature the role of the family physician in regard to such increasingly important problems as disability evaluation, putting the cardiac back to work, workers with emphysema and industrial dermatoses. A special clinical-pathological conference, as well as a medical-socio-economic session, have been planned. In addition, of course, all the usual features connected with the Indiana State Medical Association annual convention will take place.

If you haven't received your preliminary program, please drop the headquarter's office a line and one will be mailed to you. Make your plans now to be with us in October.

## Auto Crash Injury Research

AUTOMOTIVE Crash Injury Research started in Indiana in 1950 and has returned several times for further analyses. In the 15 years of its study, it has collected medical and engineering data on more than 63,000 accident cases in 28 states. It has now returned to Indiana yet another time to collect information on the precise causes of injuries in auto accidents involving cars manufactured during the past four years.

Many of the new automobiles are equipped with safety devices that have been recommended as a result of ACIR research. Further observation will determine the efficacy of the improvements and will possibly highlight other hazards to be eliminated in the future.

The project in Indiana entered its third six-month phase in May in Bartholomew, Jackson, Johnson, Monroe, Morgan, Lawrence, Brown and Jennings counties. Special report forms are stocked in the local hospitals for the convenience of physicians in reporting the exact nature of injuries.

As has been the case before, all reports will be analyzed by the Cornell Aeronautical Laboratory which in turn reports periodically to the automotive industry. Thousands of lives have been saved as a result of the research so far. The need for further work is obvious.

## PMA Establishes Foundation

THE Pharmaceutical Manufacturers Association has established a Foundation for the promotion of public health through scientific and medical research.

Three main purposes were specified at the organizational meeting. They are: (1) To plan and initiate scientific and medical research activities; (2) To collect and disseminate to the public the results of these activities; and (3) To provide financial aid to selected individuals or educational institutions, corporations' trust funds or foundations whose purposes are scientific, educational or charitable.

Medical and scientific research has always been comfortably at home with the pharmaceutical industry. It devotes a greater portion of its funds to research than does any other great industry. Its research laboratories have contributed a wealth of new drugs for the health and happiness of mankind.

It is indeed appropriate that pharmaceutical manufacturers should contribute their talents and funds to a collective venture such as this after and in the midst of an ample demonstration of the rewards of research on an individual company basis.

Dr. Austin Smith, PMA president, will be president of the Foundation. Dr. Smith has announced that work will begin on a modest scale, and that the first task of the Foundation will be to assemble data on what is being done in the field by industry, research and educational groups.

The Foundation may possibly take over the administration of color additive tests begun three years ago with the support of some 30 PMA member firms. Support of the recently organized Registry for Tissue Reaction to Drugs, established in the Armed Forces Institute of Pathology, is under consideration as a Foundation activity.

## Editorial Notes...

**Pasteurization of fresh seafood by cobalt radiation is being provided on an investigational and research basis at Gloucester, Massachusetts, by the Atomic Energy Commission.** The new Marine Products Irradiator became operational April 19, 1965. It is capable of processing seafood at the rate of one ton per hour. Reduction of bacteria is accomplished without heating the product. It has already been determined that radiation pasteurization doubles or triples the shelf life of fresh unfrozen seafoods.

Taste and other qualities are not changed.

**Birth defects as a result of German measles (rubella) will be studied on an intensive scale in New York City.** New York University Medical Center has a grant of $15,000 from the New York Chapter of The National Foundation for this purpose. A recent epidemic of rubella in and around New York City has apparently produced congenital defects in unusual numbers due to the large number of pregnancies complicated by rubella in 1963 and 1964. It is estimated that nationally the epidemic resulted in as many as 20,000 infants with defects and in 30,000 fetal deaths.

**Insurance forms have been simplified again.** The Health Insurance Council and the AMA simplified and standardized a set of health insurance forms several years ago. Experience prompted further simplification and the reduction of the types of forms to one single form. The HIC master form has been reworded in places and contains all questions necessary for any insurance company in a standard sequence. Individual insurance companies adopting the form will omit the questions that are not applicable to their type of contract but will maintain the same order of questions as on the master form. No approved form may be larger than 8½ x 11 inches.

**The traditionally immaculate white, starched nurses' uniforms may be on the way out, and if so, for a good reason.** The Gainesville, Florida, Hospital and Clinic has given colored dresses with street hose and shoes a try and report that patients like the colored scenery better. Testing on alternate days in the pediatric department demonstrated that children were happier, more easily managed and ate better when attendants were clothed in color. Since adults are all related to children, maybe the new trend will spread all over the hospital.

**Penicillin may cross-contaminate other drugs during manufacture.** The amount involved is extremely small but sufficient to cause serious reactions in patients sensitive to penicillin. Until recently it was expensive and almost impossible to detect small but critical amounts of penicillin in other drugs. This may now be done by paper chromatography at small expense. The technic was designed to detect phenethicillin. Penicillins G and V may also be detectable by the same method.

**Inventory control is extremely important in a business, such as a wholesale drug house, which must maintain fresh stock and deliver items promptly and on short notice.** Rogers Wholesalers of New York maintains two warehouses, 30 miles apart, each with 28,000 drug items. They supply 12,000 retail druggists. Honeywell has installed a computer in each warehouse and linked them through a high-speed leased telephone line. The two machines maintain accurate inventory control, do the invoicing and accounts receiveable, as well as preparing purchasing records and market analyses.

**The intramural cost of hosting research activities supported by outside grants is considerable.** When the federal government began supporting small programs of research years ago, there was a theory that the benefits received more than offset the local expense involved. Later the National Institutes of Health reimbursed medical schools for the indirect costs to some degree but never for more than 20% of the grant. Regulations are now being altered to allow reimbursement at a higher rate than in the past and more often up to the allowable maximum of 20%. Schools still must theorize that the intangible benefits are substantial—the national average for indirect costs now stands at 28.2%.

**The dollar volume of health insurance continues to climb.** The total of health insurance payments by insurance companies alone for 1964 was $4.7 billion—an increase of 12.2% over the former record in 1963. A decade of growth is even more impressive. From 1953 to 1963, payments by insurance companies were up by 280%, to $2.05 billion and payments by Blue Cross-Blue Shield and similar health care plans were up by 241% to $2.5 billion.

**Patients usually do better when they are told the essential truth concerning an unfavorable prognosis than they do when they are deceived.** The truth, no matter how

grim, is better than the fear of a suspected but unknown calamity. Recently this was verified to be true even for children by the experience of the staff of a National Cancer Institute ward for leukemic children. Deception was practiced for many years with unsatisfactory emotional results. The children instinctively knew as soon as a parent was told of the fatal prognosis. Secrecy was not possible and indeed was damaging. Since the patients have been informed of their diagnosis and prognosis, everyone is better off emotionally — the patients, the parents, other relatives, friends and the ward staff. ◄

## State Poison Information Center

The Indiana State Board of Health, by law maintains a complete file of information on all hazardous "trade name" products sold in the state. Frequently, physicians calling for information as to ingredients of compound products desire to discuss the latest treatment information as well.

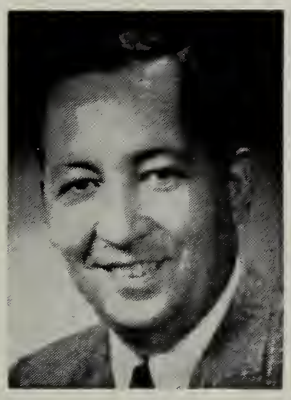
To insure that a physician will be available at all times to give this information, the principal poison information center has been changed from the Indiana State Board of Health to the Marion County General Hospital. The State Board of Health will continue to be responsible for and will insure that the latest information is on file at the new center.

All poison emergencies that cannot be handled by calling a local hospital or an *area* poison control center should be referred to Marion County General Hospital, 960 Locke St., Indianapolis, Melrose 6-6331, Extension 211, Area Code 317. Tell the switchboard operator you have a poison emergency. A complete listing of area poison control centers appears in the Yearbook Issue (June) of this *Journal* each year.

# President's Page

Recently our nation observed a weekend massacre on the highway. Over 500 people lost their lives during the July 4 weekend.

Dr. Charles Hudson, in his acceptance speech as president-elect of the American Medical Association stated "that medicine must maintain its position as a professional society and continue its activity in prevention, treatment, and study of disease and human suffering."



With the above challenge in mind, may I encourage the physicians of Indiana, to evaluate the use of tranquilizers, sedatives, and stimulants by the driving public. Perhaps a second thought in regard to the habits of an individual who is taking these drugs and a reminder by the physician may help protect the driver and innocent bystanders from injury.

The Indiana State Medical Association has been a prime activator in prevention of auto accidents. We are proud of our past in instigating auto crash injury research which is now nationally accepted and is fostered by Cornell University.

Our past activity, too, in cooperation with the Indiana State Police, in all facets of auto injury, and our Auxiliary safety program, demonstrates our continuing interest in furthering better care for the American public. We should affirm the slogan "If you drive don't drink," or conversely, "If you drink don't drive."

Remember October 11 through 14 — your annual convention dates.

Jon Black M.D

# The Woman's Auxiliary

## REPORTS TO ISMA

August is, to my way of thinking, a perfect month for vacationing. Weatherwise it is fairly constant, without abrupt temperature changes, lulling one into a sense of relaxation. But like angry buzzing flies are the small reminders of the busy month to follow and once aroused from lethargy, "conscience" takes over to break the spell. Hopefully the great awakening can be pushed away until Labor Day.



With the children returning to classes and the tempo of everyday living speeded up, the civic and social organizations assert themselves and send out the clarion call. As responsible citizens we respond and vacation time is over.

Since doctors haven't the time to participate in all the civic affairs expected of them, the wives are frequently the "active" citizens representing the medical man in community projects. Before they realize why, they have become involved not only in the PTA and Child Study Club but too many other organizations.

Engaged in pure public relations and service work, the auxiliary to the medical association has formed committees of Disaster Preparedness, Health Careers, AMA-ERF, Mental Health, Rural Health, Safety, International Health and Community Services. These channel activities into basic people-to-people fields, supplying informative, educational material and encouraging community cooperation.

Exchange of ideas, experiences and educational material was responsible for the formation of area workshops each fall and these are now established for September 14th, 15th and 16th beginning in French Lick and moving north to Indianapolis and lastly to Logansport. On the local level, in the county, a member may be selective in the particular field she chooses, based on her special talents and interests. By concentrating energies and activities, a more perfect and satisfying result is realized. Hopefully an auxiliary with direction from it's medical association, working together, could present an acceptable plan for improved community health.

Ruth V. Dunstone

Recommended Dosage of Lomotil Liquid to Control Diarrhea

File: Diarrhea

# LOMOTIL®

| Age | INITIAL LOMOTIL LIQUID DOSAGE* |
|---|---|
| 3-6 mo. | ½ tsp. t.i.d. (3 mg.) |
| 6-12 mo. | ½ tsp. q.i.d. (4 mg.) |
| 1-2 yr. | ½ tsp. 5 times daily (5 mg.) |
| 2-5 yr. | 1 tsp. t.i.d. (6 mg.) |
| 5-8 yr. | 1 tsp. q.i.d. (8 mg.) |
| 8-12 yr. | 1 tsp. 5 times daily (10 mg.) |
| **Adult** | 2 tsp. 5 times daily (20 mg.) (or 2 tablets q.i.d.) |

*Based on 4 cc. per average teaspoonful.
**Note:** After diarrhea is controlled the initial dosage can usually be reduced to meet the requirements of the individual patient.

## LOMOTIL® TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

**Precautions**
Lomotil is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

**Cautions and Side Effects**
Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

# Reflections of A General Practitioner on the Current Status of the Medical Profession

ROBERT P. ACHER, M.D.
Greensburg

THE medical profession today faces problems that seem staggeringly complex. I wonder if the complexity doesn't stem partly from some of the deep-rooted illusions that have plagued the medical profession ever since its emergence from the superstitions and customs of early civilization.

One of the illusions to which I refer is the seeming necessity for the doctor to assume the "omnipotent image." The public, the patient, even the medical societies and some doctors themselves like to endow the profession with this image, both individually and collectively.

Perhaps the root of the problem between the public and the medical profession lies in the unwillingness of the public to give up this image. They assume that by transferring the problem to the government, they will be able to retain this comforting illusion. Let's face it, the illusion is not realistic in this modern age. Until the last decade or so, the more resourceful members of our profession could successfully maintain this illusion, with obvious benefits to the public and to the profession, but with the great expansion of knowledge in so many divergent fields, it is now impossible for even the most brilliant of our contemporaries to maintain the all-encompassing, comfortable feeling of enough knowledge and prescience to cope with any situation, medical or otherwise.

I feel perhaps that the air could be cleared a great deal if some of the problems of the relationship between the medical profession, the public and the distribution of medical care were more fully comprehended by the medical profession and the public.

I agree that there may be many areas in the United States where the distribution of "medical center" type medical care may seem inadequate, but when you assess the general health and vital statistics of these areas and compare them to the same parameters of areas where "medical center" type care is readily available it may appear that there is surprisingly little difference. The real difference is that in the areas of so-called inadequate medical facilities, the public and the doctors—out of necessity—have been forced to use the available medical facilities more realistically, hence the remarkable lack of difference in the quality of medical care.

It seems to me that it would be helpful to the solution of some of the problems of medical care distribution if we were to study these areas and learn how it is that such good medicine can be practiced, and then apply what we learn to the rest of the country. It may prove that most of the hue and cry about inadequate medical care is due to faulty and unrealistic doctor usage.

### Educate the Public

The American Medical Association could well afford to give this problem some attention and develop a program that would enlighten the public, gently, meaningfully, realistically and without malice, as to their truest and best interests in individually and collectively maintaining their health.

To assume that the mere provision of facilities and doctors is going to solve the problem of individual and collective health, is the cruelest assumption that could be foisted upon the American public. If organized medicine could get back to the basis of "We are here to help *you* help *yourselves*," the problems might be more clearly thought about, understood and then more effectively dealt with.

The aim of organized medicine should be to wage a campaign to bring to the patients, through their doctors, the understanding that it is in their best interests to accept modern medicine realistically and not to expect omnipotence from their doctors and the whole science of medicine; to teach them to accept certain tentativities in medical knowledge, their doctors and in themselves. If this were done, honestly and sincerely, in every doctor's office, many of the problems between the medical profession and the public might evaporate—at least they would certainly diminish.

Now you may think, perhaps, that the foregoing is all well and good but that I have offered nothing constructive as to how these suggested solutions to the problems can be accomplished. This is where so many erudite articles and scholarly presentations of the problems of medicine fall down and become meaningless.

It is fascinating to me how a brilliant human mind can dissect a scientific problem into its basic elements and then elucidate these basic elements for the solution. Yet when a problem presents itself that is mixed with the brilliant mind's personal or emotional total adjustment to relating itself to external circumstances, that same mind utterly ignores, evades, denies or, for some reason, fails to deal with, discover or dissect that problem into its basic elements. The more brilliant the mind, the more skillful and convincing the evasions and denials become.

Since Homo sapiens possesses a reasoning brain, and since human problems are related to the functioning of this human brain, it appears to me that the solution to many of these problems lies in the elucidation and dissection of the elements and factors involved in the external and internal manifestations of this human brain and then the objective application of what we find to the present collective and individual problems—however painful this may be.

Most of the difficulties in human interpersonal relations, which may be the basic problem that confronts today's society—national and international—not only in medicine but in politics, business and sociology, may be the result of one of the basic deficiencies in the function of the human brain, that is, the capacity of the human brain to deceive itself. This is well illustrated by the brilliant and resourceful minds that study and elucidate the functions of the human brain and arrive at well supported and scientific conclusions of common patterns of behavior, but who are unwilling to admit that their *own* brain is subject to these patterns of functioning, and stoutly evade application of their conclusions to themselves!

### The Blind Cannot Lead the Blind

Decades of study of the human brain have presented increasing evidence that every sensory impulse received by the brain is recorded permanently somewhere within this mysterious organ. Therefore, one could come to the plausible conclusion that our behavior at any given moment is influenced by, or may even be the result of, the sum total of past experiences combined with the species pattern, the genus pattern, the order pattern, the phyla pattern and the patterns common to all living things, plus the patterns or connections that may be peculiar to each individual according to the uniqueness of his personal genetic structure.

It would appear then, from this hypothesis, that the first step toward the correction of some of the problems of the distribution of medical care, is for the doctors to learn to understand themselves. To realize that they too are heir to and employ all the mechanisms and manifestations of the function of the human brain. How can they objectively separate their own defenses, evasions, denials, substitutions and identifications, etc. from those of their patients if they do not understand themselves and are cognizant that they are employing these mechanisms and not confusing them with the similar mechanisms employed by their patients.

I suggest that a survey be made to determine just what the unrealistic fears of doctors are; fears that make their defenses so inappropriate and seemingly unrelated to the totality of external circumstances. A survey should also be undertaken to ascertain just what the public expects of doctors.

An analysis of these two surveys should then be made, the conclusions correlated and the findings reduced to a few succinct,

well supported statements which should be publicized in an all-out "Madison Avenue" saturation campaign.

**Mutual Understanding Imperative**

In this manner perhaps it may be possible to get the doctors and the public to understand one another, and themselves, better. Since human progress may be the result of informed, friendly, understanding communication between people, more realistic solutions to our seemingly overburdening present problems may be forthcoming.

I am aware that I have made a lot of assumptions in the foregoing and that maybe I have revealed more about myself than the subject I have discussed. I am also aware that I haven't documented my statements with much real knowledge. But I am a general practitioner which does not admit of an extensive knowledge in any one, specialized field. Therefore my knowledge cannot help but be superficial and what I have written doubtlessly reflects this. But it is my job to evaluate the whole gamut of medicine so that I can lead my patients as realistically as possible through the maze of modern medicine so that they can defend themselves from themselves—and perhaps from me—and intelligently use the facilities of modern medicine to their greater benefit.

I feel that trends and evaluations do not so much depend upon depth of knowledge in any one particular field but upon the basic honesty and capacity of the evaluator to recognize his own limitations and include them in his evaluations. I also feel strongly that the position of modern medicine has to be interpreted to the public by people similar to myself and that by communicating our thoughts about the problems, we may make some contribution toward more practical solutions.

For better or for worse, I submit these thoughts—I trust you may find them useful, and perhaps also find some way to make them more useful still. ◄

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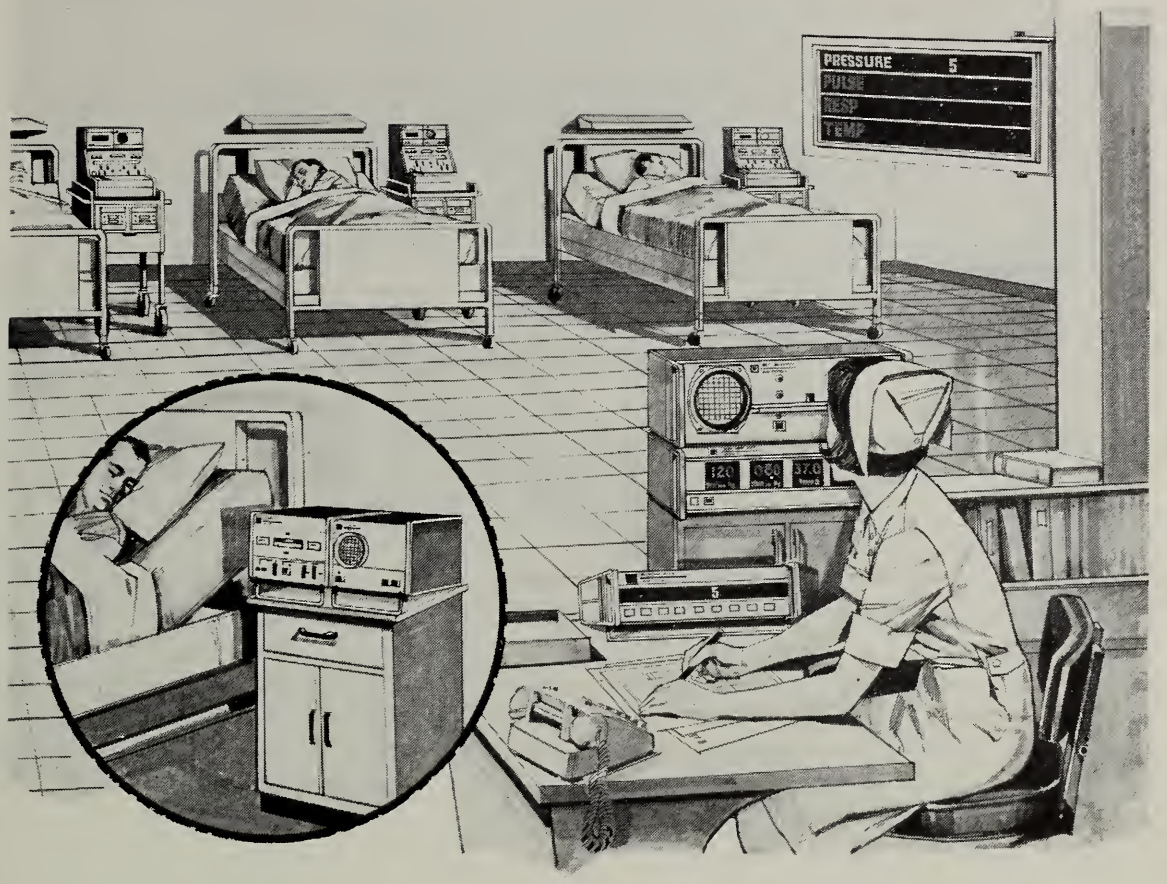
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# Report on Actions of the House of Delegates

## American Medical Association
## 114th Annual Convention
## June 20-24, 1965
## New York City

INDIANA DELEGATES to the American Medical Association convention, June 20-24, in New York City, played an important role in the proceedings this year.

Dr. Lester Bibler, Indianapolis, was re-elected to the 12 member Board of Trustees of the AMA for a three-year term.

Assignments to AMA Reference Committees went to Dr. Guy A. Owsley, Hartford City, and Dr. Jack E. Shields, Brownstown. Dr. Owsley served on the Public Health and Occupational Health Reference Committee and Dr. Shields on the Legislation and Public Relations Committee which considered the problem of "Medicare."

This latter committee's activity was lauded by the speaker of the house of the American Medical Association, Milford O. Rouse, and by the House of Delegates for the long hours of work, conscientious effort and resultant report to the house.

James A. Waggener, Executive Secretary of the ISMA, was re-elected secretary-treasurer of the Conference of Presidents and Officers of State Medical Associations, a position to which he has been elected for 12 consecutive years.

Resolution 49 on the payment of the fees under a government-sponsored medical care program was introduced by Indiana, and with some modifications, was adopted in its essentials by the American Medical Association's House of Delegates.

The final resolve of the Indiana resolution stated "That physicians inform all third parties that effective January 1, 1966, physicians will participate only on the basis that they receive their usual and customary fee for like services as paid for by the private paying patients."

During the discussion of this resolution on the floor of the House of Delegates, "usual" fee was defined as that fee usually charged for a given service by an individual physician to his private patient (i.e. his own usual fee).

"Customary" was defined as a fee within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county.)

An effort was made in the house to insert the term "reasonable" into the reference committee report on this resolution. Proponents defined "reasonable" fee as a "fee which meets the above two criteria, or in the opinion of responsible medical association's review committee, is justifiable, considering the special circumstances of the particular case in question."

The Indiana delegation resisted insertion of the term "reasonable" based on what, they termed, would mean to some, lowering the fee. The term, they said, was subject to too broad an interpretation. Motion to amend the reference committee report to utilize the term "reasonable" was defeated.

The reference committee, which reviewed resolution 49 came out with this statement as a substitute for the Indiana resolution:

> "It is recommended that when government assumes financial responsibilities for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in the government supported program should be on the basis of usual and customary fees."

Other items which came before the House of Delegates besides Federal health care legislation were the report of the President's Commission on Heart Disease, Cancer and Stroke; The Gundersen Committee

report on organization of the House of Delegates and a plan for a new method of establishing AMA scientific sections.

Dr. Charles L. Hudson of Cleveland, Ohio, a member of the AMA Board of Trustees since 1961, was named president-elect of the association. He will take office as the 121st AMA president in June, 1966, succeeding Dr. James Z. Appel of Lancaster, Pa., who was inaugurated at the Sunday opening session of the house at the New York convention.

The 1965 AMA Distinguished Service Award was won by Dr. Tinsley R. Harrison of Birmingham, Ala., for his outstanding work in the field of cardiovascular diseases.

Final registration figures reached a grand total of 64,517, including 24,268 physicians, the largest physician registration in the association's history.

### Health Care Legislation

Most controversial issue before the house was that of nonparticipation under any so-called "Medicare" law that might be passed by Congress. This subject came up in various ways in nine resolutions and in portions of Dr. Appel's inaugural address.

The house recommended that "the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

In adopting a substitute resolution, the house declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country.

"When the fate of the pending medicare legislation is determined, this house will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary.

"In keeping with the testimony before your committee, and the expressed policies of this house, this action should in *no way* be interpreted as a change in Section 6 of the "Principles of Ethics" of the American Medical Association which plainly states: 'A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care'; and that this House of Delegates reaffirm the principles of the Bauer amendment adopted in 1961.

"The House of Delegates reaffirm the nine principles for standards of health care programs as adopted by the House of Delegates in its special meeting February 7, 1965, and amended to read as follows:

'(1) No person needing health care shall be denied such care because of the inability to pay for it.

'(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

'(3) Every level of government, municipal, county, state and federal, should assume a responsible share in the financing of such programs.

'(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.

'(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.

'(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

'(7) Eligibility requirements for benefits should be fair, realistic uncomplicated and practical.

'(8) Any such health care programs should provide funds only, and not direct services.

'(9) Funds for such programs may come from general tax revenues and not from social security taxes.'"

### Offer to President Johnson

In a related action, urging that government seek the advice of the medical pro-

fession on health legislation, the house adopted a resolution which included the following statements:

"This House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States.

"The House of Delegates of the American Medical Association instruct the Board of Trustees of the American Medical Association to embark immediately on an active campaign to inform the membership of the American Medical Association of the grave considerations in adhering to our principles of ethics posed by legislation now pending before Congress.

"The American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association.

"The American Medical Association intensify its efforts to modify all such pertinent legislation, employing the necessary means and appropriate actions to the end that the health of the public and the pursuit of excellence in medicine be unimpaired by such legislation.

"The American Medical Association make every effort to continue, and where necessary, to expand its communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

### The DeBakey Commission Report

In considering seven resolutions involving the report and recommendations of the President's Commission on Heart Disease, Cancer and Stroke, the house adopted a substitute statement which resolved that:

"The American Medical Association point with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"The American Medical Association oppose those particular commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education, and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care.

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"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the board, its councils, and the association members."

### The Gundersen Committee

Action on the Gundersen Committee report reviewing the size, make-up and functions of the House of Delegates was postponed until the 1965 Clinical Convention in Philadelphia.

The House adopted a reference committee report saying:

"It was apparent that if the organization of the House of Delegates of the American Medical Association, which is of paramount importance to the efficient and productive operation of the association, is to be thoroughly studied by the delegates, more time will be required."

The Gundersen Committee was appointed an ad hoc unit at the directive of the AMA House in June, 1963. The committee, which is chaired by Gunnar Gundersen, MD, La Crosse, Wis., a past president of the AMA, brought in an extensive 35-page report.

The committee pointed out that certain aspects of its work were unfinished, particularly those dealing with the function of the AMA scientific sections. The AMA house action recommended that the committee continue its study of scientific sections.

### Organization of a New Section

In a report to the Board of Trustees, the Council on Postgraduate Programs affirmed its belief that the establishment of a new section is an important change in the AMA structure, and submitted a procedure for evaluating the qualifications for a new section and the scientific programs of all sections.

In brief, this procedure provides that (1) the group requesting formation of a new section submit to the executive vice-president a written request for approval; (2) the request be transmitted by the board to the Council on Postgraduate Programs for evaluation of the petition; (3) if approved by the council, a mandatory trial period of two years as presently in effect be provided under the auspices of the council; and (4) after such trial period, a recommendation for acceptance or denial of the petition for the establishment of a section be made to the board.

The house approved the recommendation, with certain word changes, and suggested that it be sent first to the Gundersen Committee and then to the appropriate AMA council for consideration.

### Miscellaneous Actions

In dealing with 73 resolutions and numerous reports from councils, committees and the Board of Trustees, the House of Delegates also:

Urged medical schools and agencies concerned with continuing education to incorporate "appppropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance and proper use of cancer registries in hospitals, but that the establishment of such registries should not be made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals.

Instructed the Council on Medical Service and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principle of freedom of choice" of pharmacists be maintained.

Referred to the Board of Trustees a resolution calling for the AMA to caution the public against discontinuing voluntary health insurance policies and prepayment plans for persons over 65 in "anticipation of pending legislation."

Reaffirmed its policy concerning the practice of radiology, pathology, anesthesiology and physical medicine as medical and not hospital practices.

Reaffirmed AMA policy that human

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blood, as living tissue, should not be purchased under insurance contracts. It was recognized that exceptions may be necessary when there is need for unusually large numbers of transfusions, or whenever volunteer blood donors are not available.

Urged state and local medical societies to encourage the development of the Explorer Scout Program for Medical Specialty Posts and noted that about 150 of the 21,000 Explorer Scout posts in the country are directly related to health.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people, specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the AMA encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Directed the board to review the subject of federal assistance for operating expenses for health or medical education facilities.

Directed the board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

Referred to the board for study a resolution calling for "a program of purchase of health insurance . . . in every state, subsidy for which shall be by federal-state participation," under which "extension of coverage shall be to all needy persons regardless of age."

Also referred to the board for consideration and appropriate action a 10-point legislative program outlined by the Minnesota delegation.

The house received a series of resolutions urging approval of an American Board of Family Practice. All were referred to the Council on Medical Education.

Urged the Council on Medical Education to establish a standard date of appointment for all approved residency training programs.

Encouraged state and county medical societies to participate in the formation of State Associations of the Professions, "to provide a vehicle, for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit."

Amended the bylaws to provide that the vice-president shall succeed to the presidency should the president die, resign or be removed from office.

Accepted a Board of Trustees report stating that it had referred to the joint AMA-American Bar Association committee a previously introduced resolution designed to present a grievance against alleged abuse of legal processes, characterized in the resolution as "vexatious litigation."

### Opening Session

Dr. Appel, expressing his personal opinion in his inaugural address at the Sunday session, said that if the omnibus Medicare bill is passed by Congress, the medical profession must do all it can to develop the good points and eliminate the bad points of the law. He declared that, regardless of per-

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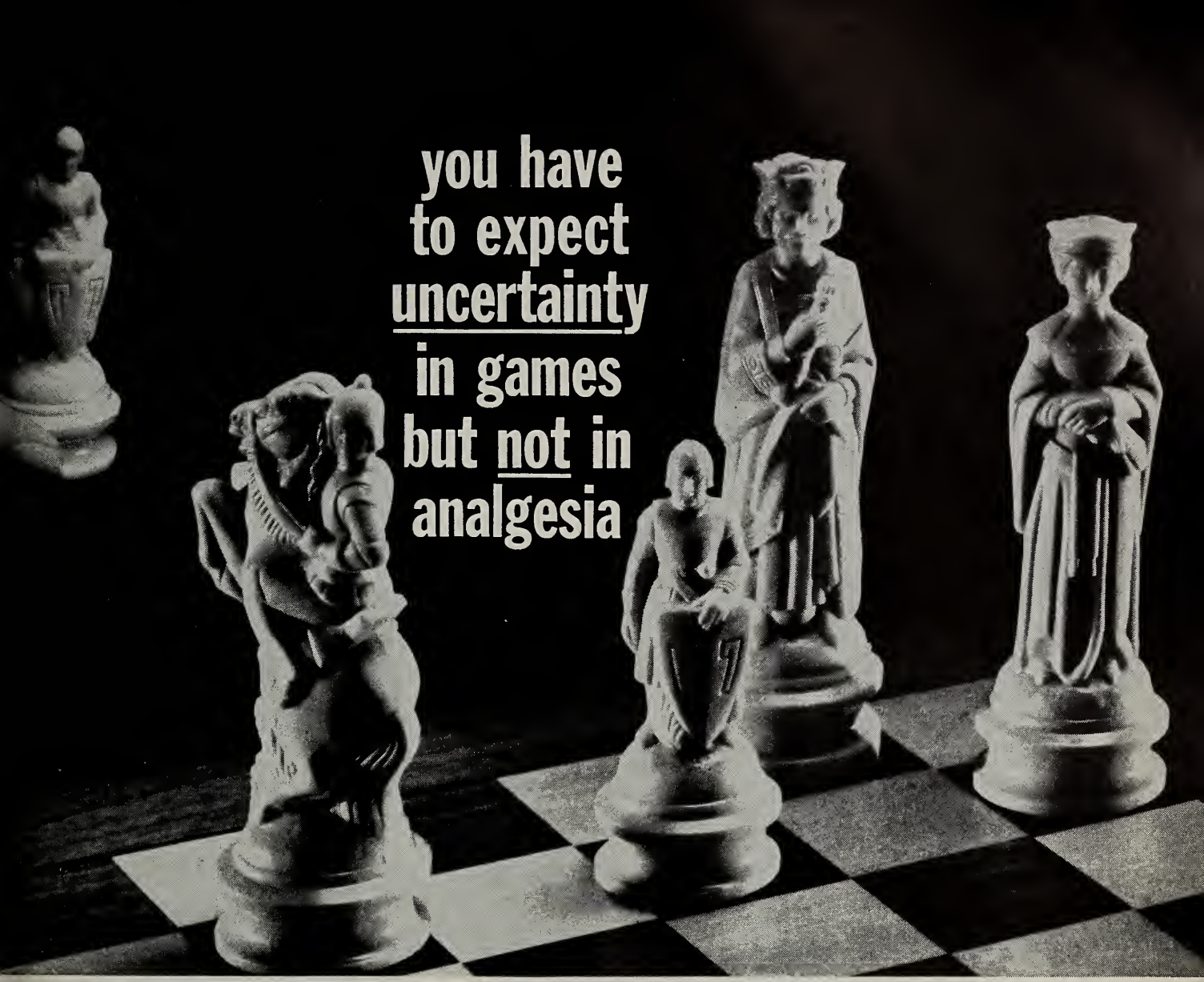


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sonal opinion, "we do not have the right—either as physicians or citizens—to violate a law or to violate the spirit of the law or its intent." Outgoing president Donovan F. Ward pointed out:

"If it were true that the public climate was the dominant factor affecting the decisions of those who make legislative history, we now would be winning both in the House and the Senate."

### Election of Officers

Dr. Hudson's unexpired term on AMA's Board of Trustees will be filled by Dr. Irvin E. Hendryson, Denver, Colo. Dr. Hendryson will serve until 1967.

Re-elected to the board for three-year terms were: Drs. J. B. Copeland, Austin, Texas; Gerald D. Dorman, New York and L. O. Simenstad, Osceola, Wisc.

W. Andrew Bunten, M.D., Cheyenne, Wyo., was elected to a one-year term as the association's vice-president.

Dr. Milford O. Rouse of Dallas, Texas, was re-elected Speaker of the House of Delegates, and Dr. Walter C. Bornemeier of Chicago was re-elected vice speaker.

Elected to the Council on Medical Education were Dr. Bland W. Cannon of Memphis, Tenn.; Dr. William R. Willard of Lexington, Ky. (to succeed himself) and Dr. Earle M. Chapman of Boston, Mass.

Named to the Council on Medical Service were Dr. C. A. Hoffman of Huntington, W. Va., and Dr. Russell B. Roth of Erie, Pa., who was re-elected unanimously. Dr. George D. Johnson of Spartanburg, S. C., member of the Council on Constitution and Bylaws, was also re-elected unanimously.

Dr. James H. Berge of Seattle, Wash., was named to succeed himself on the Judicial Council. ◄

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- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.

AMA-ERF

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**Education and Research Foundation**
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# Medicine At Law

## DECISIONS AND OPINIONS

Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.

*Surgeon Not Liable for Patient's Thrombophlebitis Following Varicose Vein Surgery* — A patient who developed thrombophlebitis following removal of the saphenous vein of her right leg was not entitled to recover damages in a suit against a surgeon, where she failed to show that her condition was due to any negligence on his part, a Texas intermediate appellate court ruled.

The patient's right lower extremity was enlarged and was very firm and indurated. The surgeon performed a venogram and an exploratory operation of the right groin. He diagnosed her condition as thrombophlebitis.

An expert medical witness for the surgeon testified that, on the basis of the patient's medical history and the tests, the removal of the saphenous vein was proper. He also stated that the postoperative flare-up of thrombophlebitis was largely a matter outside the surgeon's control.

The surgeon testified that he gave the Trendelenburg's test and that it showed that the patency of the circulation in the deep veins was sufficient to justify the operation. The patient stated that the surgeon did not perform the test because he never placed a tourniquet to her thigh. If the surgeon did the test, the record showed no negligence on his part because his testimony was that the test disclosed no medical reason for foreseeing that thrombophlebitis would develop. If the patient's testimony that the test was not performed was true, there was still no showing of any negligence that was the cause of her present condition.

*Caton v. Richardson*, 387 S.W. 2d 683 (Tex., Feb. 22, 1965).

*Damages Awarded for Unremoved Hemostat*—An award of $5,219 was granted in a case where a hemostat was found in a patient's abdomen after surgery. The surgeon who performed the operation and the general practitioner who assisted were both held liable by a trial court as a matter of law.

The patient underwent abdominal surgery for the removal of a pre-malignant polyp in the colon and exploration of the upper abdominal cavity. A few months afterward, the hemostat was discovered and was promptly removed by the same physicians at no expense to the patient. The patient's recovery was uneventful.

*Bozarth v. Noyes*, Dist. Ct., Salt Lake Co., Civil Docket No. 151336 (Utah, 1965). (Reference: Christensen and Jensen, Continental Bank Building, Salt Lake City, Utah.)

*Settlements Reached in Suits for Failure to Give Infant Exchange Transfusion Immediately After Birth*—Suits by a child and his father against a physician and a hospital for brain damages suffered by the child as the result of the failure to give him an exchange transfusion immediately after his birth have been settled out of court. The father, who had sought $25,000, received $15,000; and the child, on whose behalf $500,000 was sought, received $75,000.

The child's mother's blood was Rh negative. The transfusion was not given until 76 hours after the child's birth. It was alleged that the physician had been negligent in failing to determine the mother's blood type and in failing to find, before the birth, that it was incompatible with the child's. The hospital was allegedly negligent

in having failed to consult its records which showed, through an entry made in 1960 when she was given a transfusion after the birth of a child that died, that her blood was Rh negative. (News Release, Portland, Ore., May 4, 1965).

*Ordinance Providing for Fluoridation of City Water Valid*—An ordinance of the City of Detroit which provides for the fluoridation of the city's water supply was held to be a constitutional exercise of the police power by the Michigan Supreme Court.

Judicial notice was properly taken of the common knowledge or belief, as evidenced by a long list of public statements, affidavits, and official actions, that fluoridation prevents dental caries and thus improves public health, the court said. The merits or demerits of fluoridation as related to public health was a matter for legislative, not judicial, determination. The ordinance was a reasonable and lawful exercise of the police power designed to protect and improve public health and did not conflict with the requirement of the city charter that pure and wholesome water be furnished.

Since the ordinance is for the protection and improvement of public health, it was immaterial that dental caries are not infectious or contagious. The fluoridation of the public water does not constitute the practice of medicine or dentistry or treatment of children by health officers.

*Rogowski v. City of Detroit*, 132 N.W.2d 16 (Mich., Jan. 5, 1965).

*Surgeon's Fee Reduced by Court*—In a suit by an orthopedic surgeon against an insurance company to recover a fee of $4,325 for services rendered in treating a patient's arm, a trial court did not err in awarding only $1,275. There was sufficient evidence to support a finding that that amount was a reasonable fee in the case, a Louisiana intermediate appellate court ruled. The patient's arm was severely injured when it was struck by the propeller of a motorboat.

The orthopedic surgeon testfied that he considered that his charge was entirely reasonable and he was corroborated in this by another orthopedic surgeon. Two other experienced orthopedic surgeons from the same area testified for the insurer. They stated, respectively, that $600 and $1,000 would have been reasonable charges for the services rendered in this case. The law is well settled that whenever a doctor's charge is contested as being unreasonable and excessive, it is within the province of a court to adjust it to conform to the charges prevalent in the area where the services were rendered. On the basis of the evidence presented, there was no palpable error in the trial court's finding that the orthopedic surgeon's charge was excessive, and its finding will, therefore, not be disturbed, the court said.

*Loomis v. Travelers Insurance Company*, 169 So.2d 544 (La., Dec. 7, 1964). ◄

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# Three Years With Resolution #26 (1)

*(One of a series prepared by Blue Shield)*

*(The following article is from a presentation made at the 1965 Blue Shield Seminar by Lowell I. Thomas, M.D., Indianapolis, Chairman of the Marion County Medical Society's Insurance Committee. A second article will be published next month.)*

To begin with, it is not strictly accurate to speak of only "Three Years With Resolution #26." This plan was preceded by eight years of pilot study in several counties in Indiana before it was approved in the special meeting of the House of Delegates on March 11, 1962. That action of approval by the House of Delegates was simply an enabling act to make it possible for Blue Shield to sell statewide a plan having no fixed indemnity schedule, but offering instead to pay the physician's usual charges, indicated by the physician himself, so long as that charge was in a range considered "usual and customary" for the service rendered in his community.

The plan could be put into effect only in those counties or districts ready to set up a local claims review committee to assist Blue Shield in determining its obligations under the terms "usual and customary." Any fees beyond that range were to be the responsibility of the patient and the physician, through understanding reached in private agreement as to the physician's fee. The triangle of three-party responsibility between patient, physician and insurance carrier was thus established.

What have we accomplished by Resolution #26? We have retained our contracts with General Motors, Ford, Chrysler, Bendix, federal and state employees and other large buyers throughout Indiana. When General Motors reviewed their experience at the end of 1962, they chose to renew their contract for the following year with Indiana Blue Shield but not with Ohio, Illinois or Texas. Ford and Chrysler and others soon followed General Motors' lead. After three years, Blue Shield still has these contracts, comprising 25% of its business. Other buyers are looking favorably on this type of coverage. Other states have come to us inquiring how this plan works, and you heard Dr. Carson say last night that our plan stood high in the nation-wide test of performance recently analyzed.

The wording of recent legislation passed in Washington, which will affect the payments for medical care of the 17,000,000 elderly people who may be covered under the amended Social Security program, indicates that the "prevailing fee program," determinined by local economic areas, may be the basis for reimbursement under the new law. We have now had ten years' experience in Indiana Blue Shield under this concept. It is entirely possible that physicians, through your instrument — Blue Shield — may be expected to give professional guidance to the insurance program which the senior citizens will be getting into. This would place us in the position of exercising some local control over a federal program.

Listen to the specific wording of the law as it now stands: *"Administration by Carriers: Basis for Reimbursement*: The Secretary of Health, Education and Welfare shall, to the extent possible, contract with carriers to carry out the major administrative functions relating to the medical aspects of the program such as determining rates of payments under the program, holding and disbursing funds for benefits payments, and determining compliance and assisting in utilization review. Correspondingly, where service is on a charge basis (to physicians), the carrier must see that such charge will be reasonable and not higher than the charge applicable, for comparable service and under comparable circumstances, to the other policyholders and subscribers of the carriers." Doesn't this imply a "prevailing fee concept" amenable to some extent to local control? We already have useful experience in this area, and I am sure we should exert every reasonable force we can in influencing the program.

"Payment by the carrier will be made on

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## RESOLUTION #26

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**AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION**
Date Nov. 28—Dec. 1, 1965
Place Philadelphia, Pa.

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date May 3-5, 1966
Place Fort Wayne

**BONE AND JOINT CLUB**
Date October 13
Place The Athenaeum, Indianapolis

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

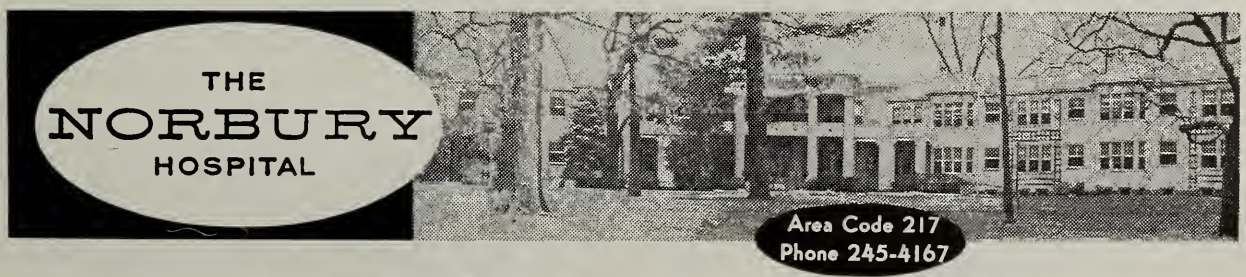
**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 12-14, 1965
Place Murat Temple, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 25-26, 1965
Place South Bend

**INDIANA ROENTGEN SOCIETY**
Date October 12, 1965
Place The Athenaeum, Indianapolis

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# ABSTRACTS

## BOOK REVIEWS

### CIRCULATION OF THE BLOOD—MEN & IDEAS

*Edited by Alfred P. Fishman & Dickinson W. Richards;* Oxford University Press, New York, 1964; 860 pages; innumerable figures, photographs and illustrations, $18.00.

This volume is, actually, a collection of a dozen monographs grouped under three topics: 1) the heart; 2) blood vessels and; 3) special circulations. World renowned authorities were assigned precise titles; the editors integrated the finished manuscripts into an harmonious whole.

The sum total is an intellectual feast of rarest gourmet quality; the Table of Contents merely hints at the delights awaiting the reader. I spent the better part of a month's vacation savoring the stimulating tidbits, chapter by succeeding chapter.

Each capsule monograph goes into depth probing the history, development and present status of the topic being discussed. The illustrations are unique; the photographs are unusual, to say the least; the explanatory summations reflect the profound scholarship and teaching ability of the particular author. The appended bibliographies run into hundreds of titles and would—literally—furnish a lifetime of industrious reading.

It is a presumption to choose any particular chapter and say it gave me "the utmost." Most diffidently, let me say that I was absolutely enthralled by Chapter V on "Electrocardiography" (Louis N. Katz & Herman K. Hellerstein). Chapter IX on "Renal Physiology" will be a most worthy memorial to Homer W. Smith who died shortly after completing this labor.

The printing of this volume is superb; the binding, up to the best. An occasional typographical error does not detract: witness, on p. 215, Newton 1642-1747. The price is ridiculously small for what is given—no wonder that this compendium had to be subsidized.

All in all, we have here an assured classic that is a treasure trove. It should be acquired right now and hoarded jealously while copies are still available. The greenest freshman and the most erudite sage will find this book marvelous stimulation for leisure hour relaxation.

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## Abstracts From Various Literature, Prepared by AMA

### GRAM-NEGATIVE SEPTICEMIA: A REPORT OF 30 CASES

J. D. Harris and L. Wilson (Queen Elizabeth Hosp., Woodville, South Australia)
*Med. J. Aust.* 1:13-16 (*Jan.* 2), 1965.

In a series of 30 cases of gram-negative septicemia, *Escherichia coli* was grown from blood cultures in 80% of the cases while *Aerobacter aerogenes, Proteus,* and *Pseudomonas pyocyanea* were responsible for the remaining 20%. Almost 50% of the cases presented with circulatory collapse, and the mortality in this group was 60%. Shock with or without pyrexia is a common presentation in gram-negative septicemia. Gram-negative septicemia is now being recognized with increasing frequency and it is important to suspect the condition in any patient with unexplained fever, with or without shock, and associated with genitourinary instrumentation, biliary tract disorders, severe urinary infections and septic abortion. If the condition is suspected, blood cultures should be taken, and streptomycin and chloramphenicol administered immediately if blind antibiotic therapy is indicated.

### CONTROLLED TRIAL OF SALICYLAZOSULFAPYRIDINE IN MAINTENANCE THERAPY FOR ULCERATIVE COLITIS

J. J. Misiewicz et al. (St. Mark's Hosp., London)
*Lancet* 1:185 (Jan. 23), 1965.

In a double-blind trial against a placebo, salicylazosulfapyridine (Azulfidine), when given in doses of 0.5 gm four times daily over a period of

Continued

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one year, reduced the number of relapses of ulcerative colitis.

## PREDNISONE AS MAINTENANCE TREATMENT FOR ULCERATIVE COLITIS

J. E. Lennard-Jones et al. (St. Mark's Hosp., London)

*Lancet* 1:188 (Jan. 23), 1965.

When prednisone was given three times daily in doses of 5 mg, it did not prove superior to a placebo in preventing relapses of ulcerative colitis.

## SPONTANEOUS PNEUMOTHORAX IN THE NEWBORN

P. G. Ashmore (750 W. Broadway, Vancouver, B.C.)

*Canad. Med. Assoc. J.* 92:309 (Feb. 13), 1965.

Spontaneous pneumothorax can occur in the newborn infant and, if not recognized, may have fatal consequences. It should be suspected in any infant in respiratory distress. It may be caused by overenthusiastic attempts at resuscitation with the pressure breathing apparatus, but more often it occurs spontaneously. When it does, it is probably due to occlusion of some of the smaller air passages with aspirated meconium. The patient with a small pneumothorax and only moderate distress may recover completely with no treatment other than observation in an oxygen enriched atmosphere. If there is considerable distress, continuous drainage of the pneumothorax should be provided with an intercostal drain and an underwater seal.

## SCAR TISSUE CARCINOMA: I

M. S. Arons et al. (107 Strand, Galveston, Tex.)

*Ann. Surg.* 161:170 (Feb.), 1965.

Experience with 56 cases of scar tissue carcinoma at the University of Texas Medical Branch is reviewed. The metastatic behavior of these lesions is emphasized, and unusual types are presented. The cases were classified as follows: (1) chronic burn scar carcinoma, (2) chronic leg ulcer carcinoma, (3) chronic osteomyelitic sinus carcinoma, (4) chronic fistula and sinus carcinoma, (5) chronic traumatic wound carcinoma, (6) acute burn and acute traumatic carcinoma, and (7) chronic scar tisue sarcoma. Twenty-two cases of chronic burn scar carcinoma are reported with a 36% incidence of local and distant metastases. The differential diagnosis from pseudoepitheliomatous hyperplasia is noted as well as the surgical treatment of these conditions.

## NALIDIXIC ACID (NEGGRAM) IN TREATMENT OF URINARY INFECTIONS

L. Reese (St. Joseph's Hosp., London, Ont.)

*Canad. Med. Assoc. J.* 92:394 (Feb. 20) 1965.

In this bacteriological and clinical assessment of nalidixic acid (NegGram), 95% of 630 gram-negative urinary pathogens tested in vitro (less *Pseudo-*

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*Swartz, C., et al.: Circulation 28:1042, 1963.

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# ABSTRACTS

Continued

*monas pyocyanea*) were sensitive to therapeutically attainable levels. Its antibacterial spectrum was surpassed only by parenterally administered kanamycin, which is potentially ototoxic. Of 70 patients treated with 0.5 to 1.0 gm every six hours for from two weeks to two months, 61 took a full course and could be assessed. In 42, the infection cleared up, in 15 the original organism disappeared with emergence of a new resistant organism, and in four the original organism became resistant. These four were on 0.5 gm. every six hours, which suggests that the higher dose may be necessary to prevent development of resistance. Only three of 13 patients with nausea had to stop the drug. There were two drug rashes and one case of diarrhea. The drug is a valuable addition to the therapy of urinary infections.

## THE ACUTE ABDOMEN OF UNRECOGNIZED BLADDER RUPTURE

I. M. Thompson (University of Missouri School of Medicine, Columbia), E. S. Johnson, and G. Ross.

*Arch. Surg.* 90:371 (March), 1965.

Of seven patients with a so-called spontaneous bladder rupture, six presented with the clinical picture of an acute abdomen of peritonitis. The diagnosis of intraperitoneal bladder perforation was missed in two patients and was affirmed by cystography in the others. The high mortality rate in cases of unrecognized or spontaneous bladder rupture emphasizes the need to consider vesical perforation in any instance of an acute abdomen when the cause is not immediately apparent or whenever micturitional disturbances are present.



I brought you a handy six pack of cod-liver oil!

## EFFECT OF HYPERBARIC OXYGEN ON PERIPHERAL BLOOD FLOW

A. D. Bird and A. B. M. Telfar (Western Infirmary, Glasgow, Scotland)

*Lancet* 1:355 (Feb. 13), 1965.

The effect on resting forearm blood flow of breathing oxygen at one and two atmospheres pressure was studied in conscious human volunteers. Blood flow was measured using the Whitney mercury-in-rubber strain gauge. A reduction in blood flow of 11.2% was observed when breathing oxygen at one atmosphere, and of 18.9% at two atmospheres. This was associated with an estimated increase in arterial oxygen content of 10% and 18%, respectively. A homeostatic mechanism is postulated whereby increasing the inspired oxygen tension produces a vasoconstriction which prevents the tissue oxygen tension from reaching high levels. If a similar mechanism operated in the presence of peripheral vascular disease, the ischemic tissues may not benefit from the increase in the arterial oxygen content and tension obtained with hyperbaric oxygen.

## RECOVERY FROM PROLONGED OLIGURIA IN ACUTE GLOMERULONEPHRITIS

D. Persoff (Atkinson Morley Hosp., The Ridgeway, Wimbledon, England)

*Lancet* 1:347 (Feb. 13), 1965.

A 39-year-old man made a complete clinical recovery, which was maintained during 22 months of follow-up, from an attack of acute glomerulonephritis complicated by 27 days of oliguria (less than 20 ml. of urine daily for 20 days, less than 400 ml daily for seven days), requiring five hemodyalyses to keep him alive while renal function recovered. Despite the severe initial course, renal biopsy showed only slight histological changes; and the slightness of these changes may account for his recovery.

## TRANSPARENT PLASTIC CAST

L. H. Wilk and J. D. VanBrocklin (University of Michigan Medical Center, Ann Arbor)

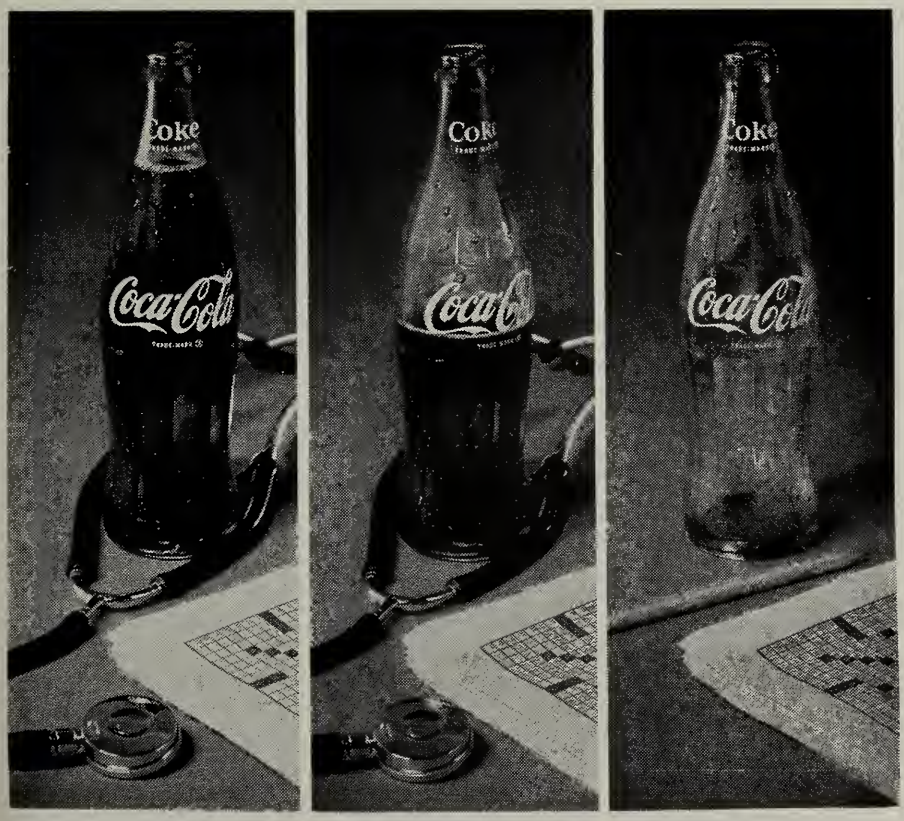
*Amer. J. Surg.* 109:150-152 (Feb.), 1965.

The transparent plastic cast is presented as another approach to the treatment of long bone fractures in paraplegic patients. It requires a little more time to prepare and is about twice as expensive as a plaster cast. It is, however, less expensive than hospitalization and affords good immobilization and observation of the patient. Treatment using the transparent plastic cast was successful in the case described in the article. ◄

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—June, 1965

| Disease | Jun. 1965 | May 1965 | Apr. 1965 | Jun. 1964 | Jun. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 1575 | 1179 | 738 | 904 | 1036 |
| Chickenpox | 304 | 312 | 324 | 723 | 244 |
| Conjunctivitis | 156 | 126 | 70 | 207 | 46 |
| Diphtheria | 0 | 0 | 0 | 0 | 0 |
| Dysentery, Unspecified | 53 | 158 | 34 | 71 | 70 |
| Gonorrhea | 443 | 438 | 322 | 312 | 245 |
| Impetigo | 143 | 118 | 48 | 146 | 63 |
| Infectious Hepatitis | 52 | 56 | 32 | 71 | 40 |
| Infectious Mononucleosis | 40 | 64 | 42 | 97 | 21 |
| Influenza | 199 | 278 | 652 | 506 | 88 |
| Measles (Rubeola-Rubella) | 629 | 705 | 523 | 6868 | 377 |
| Meningitis, Meningococcal | 7 | 5 | 6 | 9 | 5 |
| Meningitis, Other | 6 | 8 | 7 | 9 | 4 |
| Mumps | 324 | 285 | 208 | 1422 | 244 |
| Pertussis | 13 | 6 | 13 | 53 | 29 |
| Pneumonia | 182 | 133 | 199 | 344 | 85 |
| Poliomyelitis | 0 | 0 | 0 | 0 | 1 |
| Streptococcal Infection | 437 | 463 | 458 | 903 | 241 |
| Syphilis | | | | | |
| Primary & Secondary | 92 | 5 | 6 | 6 | 7 |
| All Other Syphilis | 7 | 103 | 114 | 105 | 103 |
| Tinea Capitis | 14 | 5 | 5 | 27 | 2 |
| Tuberculosis (Active) | 125 | 83 | 92 | 169 | 107 |


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### *AMA Tobacco Research Grants Awarded to Three Indiana Physicians*

The AMA Education and Research Foundation has awarded 15 new tobacco research grants for a total one-year outlay of $474,000. The 15 additional grants bring to 43 the number of tobacco research projects for which the five-year cost will be close to $3.6 million.

Included in the 15 new grants is $31,069 to Suzanne B. Knoebel, M.D., Indiana University, to investigate the effect of nicotine and other absorbed tobacco constituents on the heart muscle in animals; $13,500 to Robert B. Chevalier M.D., Indiana University to study oxygen debt accumulation in smokers and non-smokers; and $28,800 to Charles R. Echt, M.D., Indiana University, to observe the effects of smoking during pregnancy. Drs. Knoebel and Chevalier are associated with the Krannert Heart Research Institute.

### New Robins Representative

Patrick M. Rhodes, who holds a B.S. degree from the University of Iowa, has been assigned as medical service representative for A. H. Robins Company and will be working in Muncie, Indiana.

### *TB Control Recommendations Contained in Joint Statement*

Tuberculosis control recommendations are contained in a joint statement of the Therapy Committees of "The American Review of Respiratory Diseases" and "Diseases of the Chest."

The statement deals with the report of the Surgeon General's Task Force on Tuberculosis Control and points up the important contribution that practicing physicians have to make in implementing the Task Force recommendations. Physicians may obtain copies of this statement by writing the Indiana Tuberculosis Association, 30 E. Georgia St., Indianapolis 46204.

### Dr. Helwig Awarded Distinguished Civilian Service Award

The Distinguished Civilian Service Award, the highest honor accorded by the Department of Defense, has been awarded to Dr. Elson Helwig, Chief of the Department of Pathology of the Armed Forces Institute of Pathology.

Dr. Helwig is a native of Warsaw, Indiana. He graduated from Indiana University School of Medicine and interned at the then City Hospital in Indianapolis. Dr. Helwig received the Army Exceptional Civilian Service Award last year.

### *Booklet on Building Accesses Available for the Handicapped*

The Muscular Dystrophy Foundation of Marion County is making available copies of a pocket-size directory of some 200 public places in Indianapolis together with data about parking facilities, steps into the building, access to restrooms and other information of value to physically handicapped persons. The booklet may be obtained by writing the Foundation at 615 N. Alabama St., Indianapolis 46204.

### Dr. K. K. Chen Honored

K. K. Chen, M.D., Indianapolis, presently Professor of Pharmacology at Indiana University School of Medicine and formerly the Director of the Pharmacological Division of Eli Lilly and Company has been honored by becoming the 1965 Remington Honor Medalist.

The Remington Honor Medal is awarded each year by the American Pharmaceutical Association in recognition of individual service to American pharmacy. Dr. Chen was cited for "many accomplishments in the field of pharmaceutical and medical science . . . and studies which led to the introduction of ephedrine into modern medicine, his development of cyanide poison antidotes and research in connection with vasoconstrictors, digitalis, cardiac glycosides, alkaloids and new synthetic analgesics."

### Doyenne of Auxiliary Dies

Mrs. O. G. Pfaff, the widow, mother and grandmother of physicians died at St. Vincent's Hospital on June 12 at the age of 100.

Mary A. Pfaff was a charter member of the Woman's Auxiliary which was formed in 1927, the year that Mrs. Pfaff's husband, Dr. O. G. Pfaff died.

Due to her age when the auxiliary started, Mrs. Pfaff never held the office of president. However, she was always a very active member, directing much of her energies to the legislative field. She was a staunch opponent of socialized medicine.

She attended her last district meeting in 1962 at the age of 97 but was unable to attend the 1963 annual meeting due to the fact that she was in



**DOCTOR Donald Wood, Indianapolis, participated in an AMPAC National Workshop held recently in Washington, D. C. Dr. Wood moderated a panel discussion entitled "Strictly Politics." Members of the panel included (left to right) Senator Spessard Holland, Florida; Dr. Wood and Senator Everett M. Dirksen, Illinois. Dr. Frank Coleman (far right) was chairman of the workshop and is chairman of the AMPAC Board of Directors.**

California visiting her grandson Dr. Dudley A. Pfaff, Jr. The oldest member of the state auxiliary, Mrs. Pfaff retained her membership and her interest in the affairs of medicine until her death.

## *Winners in 1965 Prize Essay Contest Are Announced*

The Association of American Physicians and Surgeons has announced the winners of its 1965 Prize Essay Contest. John Brinduse of Anderson, Indiana has been awarded the eighth prize. The association also announced the continuation of the essay contest in 1966, with a full list of cash prizes.

Topics for next year's essay will be "The Advantages of Private Medical Care" or "The Advantages of the American Free Enterprise System." Details are available for sponsors of county and state contests from the association at 185 N. Wabash Ave., Chicago 60601.

## Dr. Brucer Gets Citation

Dr. Marshall H. Brucer, long known for his interest and leadership in the Medical Division of the Oak Ridge Institute of Nuclear Studies, and retired for ill health since 1961, will receive the Atomic Energy Commission Citation for outstanding service to the nation's nuclear energy program.

Dr. Brucer made important contributions to the theory, development and use of radioisotopes in medicine and especially radioactive cobalt, cesium and iodine.

## *AEC Announces Educational Assistance Grants in Indiana*

The Atomic Energy Commission has announced 56 educational assistance grants to 54 colleges and universities to provide for the purchase of laboratory equipment and fabrication of radiation sources for instructional purposes.

Included are: Purdue University for grants of $34,735 and $12,400 and Rose Polytechnic Institute for a grant of $10,000.

## Federal Courts Uphold Patent

Federal courts have upheld the validity and enforcability of Pfizer's patent on tetracycline and have already entered consent judgments against two firms who have imported unlicensed tetracycline, and sold it in violation of the patent rights.

## AMA Division Announces Change in Name

The name of the AMA's Division of Environmental Medicine and Medical Services has been changed to *Division of Socio-Economic Activities.* This change in name, announced by F. J. L. Blasingame, M.D., AMA's executive vice-president, is effective immediately.

The division, directed by Raymond L. White, M.D., includes the Departments of Community Health and Health Education, Environmental Health, Governmental Medical Services, Hospitals and Medical Facilities, Economics, Biostatistics, Occupational Health and the medical liaison representative in the Washington office. ◄

# FUTURE MEETINGS, SEMINARS, COURSES

## *One-Day Postgraduate Programs At Marion County General Hospital*

One-day postgraduate courses will be presented during the coming academic year by the Marion County General Hospital. All Indiana physicians are invited to attend and will be notified by mail at a later time. All courses have been approved by the American Academy of General Practice.

"Diagnosis and Treatment of Common Rheumatic Disorders" will be given on September 29 with Dr. Fred Priebe as course director; "Diagnosis and Management of Renal Disease," with Dr. B. L. Martz is scheduled for November 17. "The Problem of Coronary Heart Disease" on January 19 will be directed by Dr. Charles Fisch and "Diagnosis and Treatment of Common Pulmonary Disorders" with Dr. John Miller will be presented on April 27.

## *Postgraduate Course in Pulmonary Disease Offered*

The postgraduate course in Pulmonary Disease will be held at The Ohio State University, September 24-25. This course is designed to provide the general practitioner with current concepts of pulmonary disease with emphasis on practical aspects of diagnosis and treatment. Registration fee is $30.00 and registration forms may be obtained from Ohio State University, The Center for Continuing Medical Education, 320 W. Tenth St., Columbus, Ohio 43210.

## Genetic Studies Among the Amish Symposium Set

"Genetic Studies Among the Amish" will be the subject of a medical symposium to be conducted in Bluffton on September 29 from 1:30 P.M. to 9:30 P.M. The program is presented at the Wells County Fall Clinical Conference and will be held at the Dutch Mill. Authorities in genetics, sociology and internal medicine from teaching hospitals and universities will compose the faculty. Reservations should be requested by writing Dr. David G. Pietz, Secretary, Wells County Medical Society, Bluffton, Indiana.

## *Internists Group To Sponsor Meeting in Miami Beach October 7-9*

The third fall meeting of the American College of Physicians (ACP) will be held October 7-9 at the Deauville Hotel in Miami Beach, Fla. It will be the second major scientific meeting this year for the 50-year-old medical specialty society.

The three-day program will feature three major lectures, 28 clinical papers, 27 presentations on basic science and clinical investigations and four symposia on problems of importance to practicing physicians. The ACP's fall meeting will be open to members, students, interns and residents without charge and to non-member physicians upon payment of a $25.00 registration fee.

Information on the meeting can be obtained from Edward C. Rosenow, Jr., M.D., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

## Postgraduate Course on Fractures And Other Injuries Set for October

The Committee on Injuries of the American Academy of Orthopaedic Surgeons will hold the second postgraduate course on fractures and other injuries at the Riviera Motel, Atlanta, Georgia on October 11, 12, 13, and 14. The program has been arranged by an Atlanta committee under the chairmanship of Dr. Wood Lovell. The distinguished out-of-town faculty will consist of 14 outstanding teachers and 20 surgeons from the medical schools of Georgia will take part.

The course is open to all physicians. The registration fee is $75.00. Each registrant will be a guest of the committee for one luncheon and a chairman's reception on Thursday evening, October 12. Residents, interns and medical students are admitted free by a letter from their chief of service. The course is approved for 30 hours of Category II for general practice.

## *American Cancer Society Sponsors Symposium*

The American Cancer Society, in cooperation with Indiana University, the Indiana State Medical Association and the Indiana Academy of General Practice will again sponsor a Cancer Symposium this year at the I. U. Medical Center.

A reception and dinner in honor of faculty and guests will be given Tuesday, September 14 at the Columbia Club. The symposium will begin Wednesday, September 15, at 9 a.m. A more detailed program will be announced later. ◄

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# County, District News

## Clinton

The Clinton County Medical Society met June 22 to hear Dr. Charles E. Bush, Kirklin, speak on "Closed Chest Heart Massage and the Use of Defibrillation." There were 14 members present.

## LaPorte

Dr. Raymond Firfer, Berwyn, Ill., spoke on "Diagnostic Pediatric Urology" at the June 15 meeting of the LaPorte County Medical Society. Thirty-seven members attended.

## Tippecanoe

"Mental Illness" was the topic chosen by Dr. John B. Scofield, Indianapolis, when he spoke at the June 8 meeting of the Tippecanoe County Medical Society.

## Vanderburgh

Dr. Edgar L. Engel, Evansville, is the newly elected president of the Vanderburgh County Medical Society. Other officers are: Drs. Joseph C. Lawrence, president-elect; Ira L. Faith, vice-president and Robert C. Ziss, treasurer. Delegates will be Drs. Ray H. Burnikel, J. Guy Hoover, Charles M. Sinn, George W. Willison and John D. Wilson. Alternates are: Drs. William C. Grimm, Robert Oswald, James Mathews, Albert Ritz and Ralph E. Zwickel.

## Washington

Dr. Irvin Huckleberry is the 1965 president of the Washington County Medical Society. Other officers are T. Kermit Tower, vice-president and Arsenius R. Episcopo, secretary-treasurer. Delegate is Dr. Huckleberry and alternate is Dr. Tower. ◄


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# Deaths

### Charles J. Goethals, M.D.

Dr. Charles J. Goethals, 68, Mishawaka general practitioner, died unexpectedly June 2 at his home.

Dr. Goethals was a graduate from Northwestern Medical School in 1922, served his internship at St. Francis Hospital, Evanston, Ill., and went to Mishawaka in 1923 to start his practice. He was a member of the St. Joseph County Medical Society.

### Alfred S. Jaeger, M.D.

Dr. Alfred S. Jaeger, retired Indianapolis obstetrician and gynecologist, died June 4 at his home. He was 88.

Dr. Jaeger was graduated from City College of New York Medical School and did postgraduate work at Washington University, St. Louis and the University of Heidelburg. He was past president of the Marion County General Hospital medical staff and the Indiana, 7th District, Marion County and Indianapolis Medical Associations.

Founder of the woman's auxiliaries of the state and county medical associations, Dr. Jaeger had served as a staff member of most of the hospitals in Marion County, chairman of the ISMA surgical section and director of the Department of Women's Diseases of the Public Health Center. He was a member of the ISMA 50-Year Club and the Marion County Medical Society.

### Keith E. Selby, M.D.

Dr. Keith E. Selby, 64, South Bend surgeon, died June 16 at South Bend.

A former president of the South Bend Medical Foundation and the St. Joseph County Medical Society, he was a member of the executive staffs of Memorial and St. Joseph's Hospitals. Dr. Selby was graduated from the medical school at Northwestern University and did postgraduate work in Vienna, Austria and at the University of Minnesota, Minneapolis. He began the practice of medicine in South Bend in 1931. ◄

## ROSTER AND YEARBOOK ISSUES

The Roster and Yearbook issue of the Indiana State Medical Association is now available. Included in the Roster are the names of all members of the ISMA listed alphabetically and by counties, plus the names of all the Woman's Auxiliary.

The Yearbook, besides carrying the Roster, includes listings of the following: State Health Organizations; Professional Medical and Allied Organizations; Voluntary Organizations; Heads of Departments at the I. U. School of Medicine; Indiana Accredited Practical Nursing Schools; Approved Hospitals in Indiana; Approved Mental Hospitals; Licensed Nursing Homes; Poison Control Centers in Indiana; Disease Prevention by Immunization and Chemoprophylaxis and Class A Narcotic Drugs.

If you would like to order either or both of these special issues, please check the appropriate box and send it along with your check or money order to *The Journal*, 3935 N. Meridian St., Indianapolis 8.

☐ Roster — $3.00

☐ Yearbook — $5.00

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ANESTHESIOLOGIST, 34-year-old male, Indiana licensed, desires to start practicing in Indiana within a few months. Contact F. Duque, M.D., 925 Saint Joseph St., Morgantown, W. Va.

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Charges for commercial announcements are:

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DEADLINE: Fifth day of month PRECEDING month of issue.

## SPECIAL NOTICE

June issues and the 1965-66 Roster may be obtained from the JOURNAL, 3935 N. Meridian, Indianapolis.

Roster: $3.00 each.

Yearbook: $5.00 each.

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August 1965 Volume 58 No. 8

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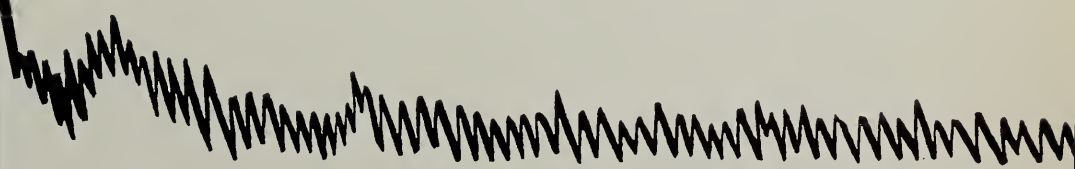
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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

Illustrations are desirable. Selection of illustrations submitted at discretion of editor and editorial board members. Cost of color illustrations must be shared by the author.

Contributors are responsible for all statements made in their articles. The editors and editorial board members may not be in agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible. However, the right is reserved to reduce in length or reject any article.

Articles are accepted for publication with the understanding that they are submitted for exclusive publication in THE JOURNAL of the Indiana State Medical Association.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 5th of the month preceding month of issue. (Scientific manuscripts must be received at least two weeks earlier if geared for a specific issue.)

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on page 961.

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| 2. | C. Philip Fox, Washington | J. S. Brown, Carlisle | Washington, 1966 |
| 3. | Marion Hagan, French Lick | Arthur L. Wagner, Jasper | French Lick, 1966 |
| 4. | Merritt O. Alcorn, Madison | Francis W. Hare, Jr., Madison | Madison, 1966 |
| 5. | Robert M. Fell, Rosedale | J. W. Somerville, Clinton | |
| 6. | William E. Murray, New Castle | Paul M. Inlow, Shelbyville | Shelbyville, 1966 |
| 7. | William C. Stafford, Plainfield | James H. Gosman, Indianapolis | |
| 8. | Lowell Painter, Winchester | Paul W. Sparks, Winchester | Muncie, June 1, 1966 |
| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | May 19, 1966 |
| 10. | Michael Shellhouse, Gary | Edward J. Dierolf, Gary | |
| 11. | Fred C. Poehler, La Fountaine | Max M. Earl, Kokomo | Peru, Sept. 15, 1965 |
| 12. | Warren L. Niccum, Columbia City | Kenneth F. Isenogle, Fort Wayne | May 18, 1966 |
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It stands to reason. They all go through the same training; they all have to pass the same tests: they all have to measure up to the same standards. Therefore, all registered nurses are alike.

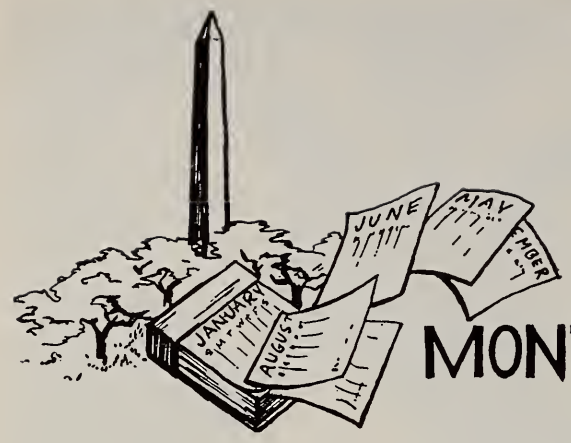
That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.






This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D.C.—Health, Education and Welfare officials are drafting rules and regulations for operation of the new Social Security medicare law.

The new law provides for persons 65 years and older a basic hospitalization plan financed with Social Security taxes and a subsidized, voluntary, supplementary medical insurance program. Both programs will start July 1, 1966.

The existing Kerr-Mills program of medical assistance to the needy and near-needy aged is expanded and combined with all the other federal-state medical assistance programs into one plan with simplified administration, a uniform grant formula, specified benefits and minimum eligibility requirements.

Self-employed physicians are brought under Social Security retroactive to Jan. 1, 1965. They will be required to pay next April $259.20 each in Social Security taxes for this year. The tax will go up to $405.90 for 1966 and rise over the years to $514.80 by 1987. Physicians were the last profession to be covered by Social Security and the only group to be forced into the system over the protests of its professional organization.

Coverage and liability for taxes for interns and residents will not begin until Jan. 1, 1966.

The new law also increases Social Security cash benefits by an average of seven percent, retroactive to Jan. 1, 1965.

To finance the new health care programs and the increase in cash benefits, both the Social Security tax base and tax rates will be increased. The tax base will be increased from the present $4,800 of workers' annual pay to $6,600 on Jan. 1, 1966.

Arthur E. Hess, who has been with the Social Security Administration since 1939 and in charge of disability insurance since 1954, has been named to head up the new SSA Bureau of Disability and Health Insurance to handle the medicare program. A spokesman said the SSA, which now has 35,000 employees, will add between 7,000 and 8,000 more in the next year to administer the program.

President Johnson went to Independence, Mo., to sign the legislation (H.R. 6675) July 30 in the presence of former President Harry S. Truman who 20 years ago proposed in his legislative program a national medical insurance plan for all ages financed by higher Social Security taxes.

## AMA OFFICIAL COMMENTS ON MEDICARE

Commenting on the medicare program becoming law, F.J.L. Blasingame, M.D., executive vice-president of the AMA, said in Chicago:




# An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

# Miltown® (meprobamate)

**Indications:** 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

**Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

**Precautions:** Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Usual adult dosage:** One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

**Supplied:** In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

*Before prescribing, consult package circular.*

WALLACE LABORATORIES
*Cranbury, N.J.*

CM-5761

Continued

"We will watch developments in this new program and offer constructive suggestions, both to Congress and to the administrators of the program, in the interest of the maintenance of the highest quality of medical care.

"President Johnson has requested that we meet with officials of the Department of Health, Education and Welfare on the development of rules and regulations.

"Following our conference with Mr. Johnson on Thursday (July 29), initial meetings were held with HEW Secretary Anthony Celebrezze, exploring arrangements for AMA and HEW review of projected regulations and of problems of administration and interpretation of the law.

"The President also asked that we report back to him in two months on our progress."

The White House conference between Johnson and 11 top AMA elected and staff officials, developed from an action of the AMA House of Delegates in New York last June. The House approved a resolution including the following two resolves:

"Resolved, That this House of Delegates restate its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States. . . .

"Resolved, That the American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association. . . ."

The first AMA-HEW conference on medicare at the staff level was held in Washington a week after the program became law.

HEW was consulting representatives of the American Hospital Association even before the legislation was signed into law.

The Social Security Administration, in administering the basic and supplementary health care programs, will utilize Blue Cross, Blue Shield, private health insurance carriers or combinations of them as "fiscal intermediaries." At this writing, they had not been named.

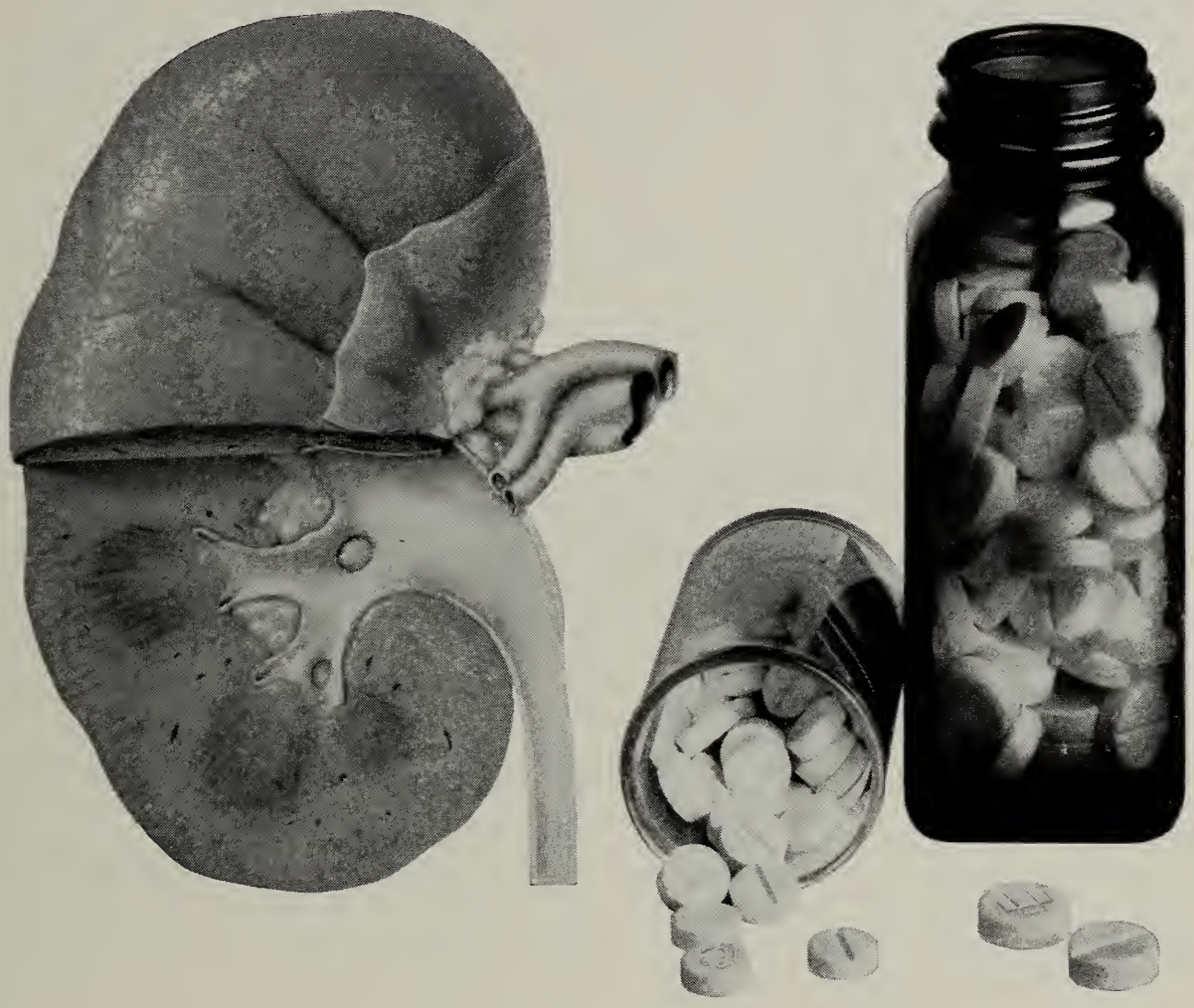
HEW said the physician will be the key figure in the basic as well as the supplementary program. He will decide upon admission to a hospital or post-hospital extended care facility; order tests, drugs and treatment; including home health services and determine the length of stay, HEW said.

As to length of stay, however, hospitals and extended care facilities participating in the program will be required "to have in effect a utilization review plan providing for a review of admissions, length of stays and the medical necessity for services provided."

Such reviews "would ordinarily be carried out by a staff committee of the institution," and include other professional personnel such as registered nurses and medical social workers in addition to two or more physicians.

As an alternative, HEW said, reviews could be conducted by a similar group outside the institution—preferably one established by the local medical society and some or all of the hospitals and extended care fa-

at Merck Sharp & Dohme...



# understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

• Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.

• From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

**where today's theory is tomorrow's therapy**

cilities in the locality.

Under the supplementary program, the patients could pay the doctor and be reimbursed 80% of a "reasonable" fee. If the doctor so chose, he could let the patient assign to him the amount the patient would be reimbursed. If payment is on the basis of an assignment, the "reasonable" fee would have to be accepted as the full payment. If the physician receives payment only directly from the patient, he can charge the amount he chooses regardless of what is determined to be a "reasonable" fee.

In determination of a "reasonable" fee, HEW said, the supplementary insurance carriers, must "assure that the charge on which the reimbursement is based is reasonable and is not higher than the charge used for reimbursement on behalf of the carriers own policyholders or subscribers for comparable services and under comparable circumstances."

## SUMMARY OF LAW'S HEALTH CARE PROVISIONS

### Basic Program

#### Hospitalization

Up to 90 days in each spell of illness. The patient pays the first $40 of hospital costs. If he stays more than 60 days, he pays $10 for each additional day up to the 90-day limit. A spell of illness starts with the first day of hospitalization and ends when the patient has spent 60 consecutive days without hospital or nursing care.

The hospitalization covers room and board, prescribed drugs while hospitalized and other services and supplies except private duty nursing and services of physicians other than interns or residents in training. Christian Science sanatoriums and psychiatric hospitals are included. There is a lifetime limit of 190 days in a psychiatric hospital.

#### Nursing Home Care

Up to 100 days in an extended care facility in each spell of illness after a stay of at least three days in a hospital. There is no charge to the patient for the first 20 days. The patient pays $5 for each day above 20, up to the 100-day limit.

#### Home Nursing

Up to 100 visits by nurses or technicians in a one-year period following the patient's discharge from a hospital or extended care facility. The services furnished must be in accordance with a program set up and periodically reviewed by a physician.

#### Diagnostic Services

Tests and related diagnostic services, other than those performed by physicians, that are normally provided by hospitals to out-patients. The patient pays $20 of the charge for each diagnostic study provided by the same hospital in a 20-day period. The patient pays 20% of the charges above $20.

### Supplementary Program

Persons enrolling in this program will pay $3 a month in premiums. The federal government will match this with a payment of $3 a month for each

Continued on page 928.

# and Robaxin®-750
## (methocarbamol 750 mg.)

(CAPSULE-SHAPED TABLETS)




It has been noted that low-back disorders frequently "...are caused by truly mechanical conditions which yield to conservative treatment."[1] Basic to this conservative treatment are bed rest, a board for the bed, and applied heat. In addition, a good muscle relaxant is often helpful, as "...muscle relaxants are useful in chronic as well as acute low backaches."[4]

Robaxin (methocarbamol) has relieved spasm and pain in cases where the patient "had not responded to conservative measures prior to drug therapy."[6] A 100-patient study showed that Robaxin provided greater relief of muscle spasm for a longer period of time without adverse reactions "than any other commonly used relaxants...."[6]

A well-tolerated[7] skeletal muscle relaxant with "specificity of action,"[7] methocarbamol leaves normal muscle tone unaffected. Moreover, there is little likelihood of sedation[7]—a considerable advantage for the patient who must remain active and alert on his job.

Significantly, clinicians advise using a muscle relaxant "early and in adequate dosage."[8] In this regard, Robaxin (methocarbamol)—*particularly in the 750 mg. dosage (2 tabs. q.i.d.)*—offers optimal therapeutic benefits without a significantly increased incidence of side effects. And just as it works well as part of the basic regimen for low-back pain, so also does Robaxin (methocarbamol) often provide muscle relaxation in such conditions as musculoskeletal injury, chronic neurological disorders, and orthopedic situations.

BRIEF SUMMARY—Robaxin (methocarbamol) Tablets: Contraindicated in hypersensitive patients. Side effects (light-headedness, dizziness, drowsiness, nausea) may occur rarely, but usually disappear on reduced dosage. Hypersensitivity reactions develop infrequently.

ALSO AVAILABLE: Robaxin® Tablets (methocarbamol, 500 mg.) Robaxin Injectable (methocarbamol, 1 Gm./10 cc.)
Robaxisal® (methocarbamol with aspirin) and Robaxisal-PH Tablets (methocarbamol with Phenaphen®).

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Robins
PHARMACEUTICALS | RESEARCH

Continued

participant. The federal share, about $600 million a year, will come from general tax revenues. The insurance supplements the basic program by covering most other major medical expenses except those for dental services, medicines and drugs.

A participant in the program pays $50 of his annual costs for the services and supplies covered. He also pays 20% of the annual costs above $50 while the program pays 80%.

The coverage includes:

Physicians' services, including surgery, whether performed in a hospital, clinic, office or home.

Up to 100 home nursing visits each year in addition to those allowed under the basic program and without any requirement for prior hospitalization.

Various services and supplies, whether provided in or out of a medical institution, such as x-ray and other diagnostic tests, radiological treatments, surgical dressings, splints, casts, iron lungs and other specified prosthetic devices, artificial arms, legs and eyes and ambulance service.

### Welfare Aid

The bill authorizes increases of about $400 million in annual federal grants to states for public assistance (relief of the needy) and other welfare programs. It consolidates the Kerr-Mills medical assistance program with five related programs and sets federal standards for the scope of benefits and elgibility of beneficiaries.

A new program of health care for children in impoverished families is established, with $185 million in grants authorized for the first five years. Grants for maternal and child health services and aid to crippled children are raised in four steps from the present level of $80 million to $120 million in 1970.

By revising the general formula for public assistance grants, the bill raises annual federal authorizations by $150 million. ◄

## I. U. Bus Tour

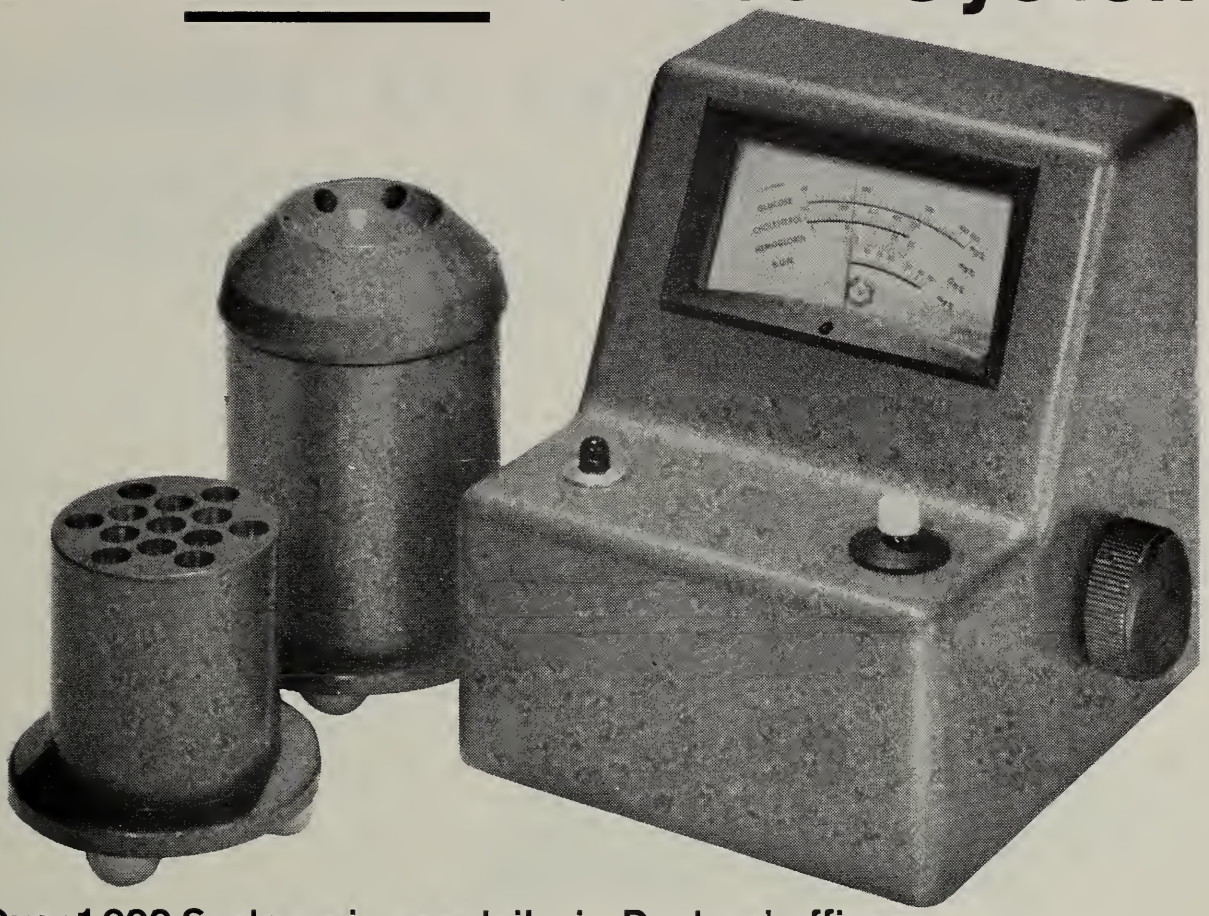
I should like to extend a warm welcome to all members of the Indiana State Medical Association who attend the annual meeting this year to visit the Indiana University Medical Center Campus on Wednesday morning, October 13, 1965. Buses will operate continuously that morning between the Murat Temple and the Medical Center where there will be several stations at which physicians may disembark and tour areas of interest, meet faculty and students.

I believe those who take this tour will be interested in the many new activities and facilities here.

My office in Fesler Hall will be open to all who wish to visit.

Very sincerely,
Glenn W. Irwin, Jr., M.D.
Dean,
I. U. School of Medicine

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**Over 1,000 Systems in use daily, in Doctors' offices.**

In your office you can have results that are accurate, rapid, dependable, using completely disposable glassware for the four blood chemistries you request most frequently.

Results are ready in minutes, permitting immediate consultation, and you can use them in full confidence since the analyses were performed *in your office*, and under *your* supervision.

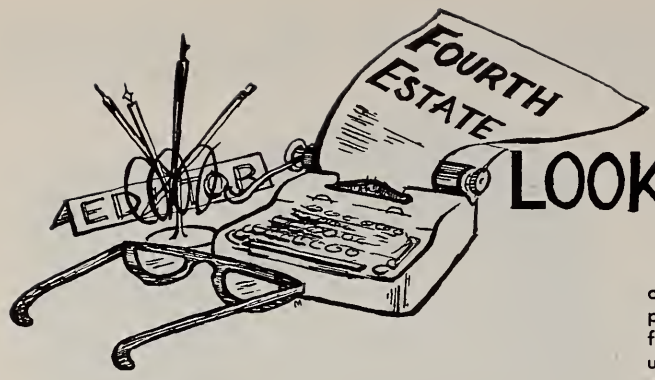
The UNITEST SYSTEM consists of the UNIMETER; a direct reading colorimeter designed expressly for your office with a matching Incubator and Centrifuge.

The Four Basic Tests, True Glucose, Hemoglobin, Cholesterol, Blood Urea Nitrogen, are color-coded to the UNIMETER for simplicity.




*For a complete demonstration visit our booth at the Indiana State Medical Association Convention on October 12-13-14.*

**BIO-DYNAMICS, INC.** **INDIANAPOLIS, IND.**




# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Public-Spirited Doctors

The physicians of Marion County in pledging $1,550,000 for our community's hospital development program are showing the highest degree of public spirit.

It is impossible at this stage of the drive to weigh the doctor's gift in terms of new health for the sick, healing of the injured and the relief of suffering, but that is how it will be measured in due time.

The overall objective of the United Hospital Campaign, which is being carried out by the Indianapolis Hospital Development Corporation, is $15,500,000. This means that the doctors plan to contribute 10% of the goal—an average contribution of $1,550 each.

This act of community-minded generosity by the doctors is in keeping with the finest ideals of a great profession.—*The Indianapolis Star*, June 7, 1965.

## The Mentally Retarded

This week *The News* features a series of articles by Frank Salzarulo on mental retardation.

Salzarulo's articles focus attention on this too-long neglected subject. His investigations reveal not only the tragedy of the condition, but the sad fact that here in Indiana facilities for helping the victims of retardation are simply not adequate.

Among the many revelations in Salzarulo's articles are these:

- In Marion County alone there are more than 22,000 mentally retarded men, women and children.
- There are but three state institutions for mentally retarded, and a waiting list of more than 1,400.
- Although the legislature two years ago passed a law authorizing counties to furnish financial help to any community center for the retarded, Marion County has not asked for such help for its local centers even though this county has the largest number of retarded persons in the state.
- The number of mentally retarded persons in Marion County today, says county welfare department director Wayne Stanton, could easily fill an institution here in the county.

The problem of the mentally retarded, clearly, is more widespread than popularly thought. Welfare director Stanton has suggested the state purchase the present St. Vincent's Hospital when the new plant is relocated in northwest Marion County; and there is also a move afoot to establish a countywide association in behalf of the mentally retarded.

Certainly action is needed. The condition is tragic, affecting individuals, families, and society. Salzarulo's articles will help, we hope, to spotlight this human problem that must be treated with compassion, understanding, and—above all—determination to help.—*The Indianapolis News*, July 6, 1965.

## Travesty on Medicare

The Administration's medicare bill has been turned into a monstrosity by the revisions written into it by the Senate Finance Committee. Under the guise of helping the poor, the new measure flouts every principle of social insurance, introduces a universal means test and raises the cost of health protection for every aged person with an income of more than $800 a year.

The revised bill is the brainchild of Senator Russell B. Long, acting in sublime dis-



# Lirugen™

## is *truly* a one shot measles vaccine.

An efficacy rate of 99% has been demonstrated with Schwarz Strain live measles vaccine (Lirugen). In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine. Additional special passages of the original Edmonston Strain by Schwarz resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.


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PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, U.S.A. DOW

regard of his obligations as Democratic whip; and it draws its philosophic inspiration from the "Every Man a King" slogan on which his father, the late Huey P. Long, built the family political dynasty in Louisiana. Its potential consequences are so disastrous that it is hard to believe it was put forward with any aim except to kill any prospect of medicare in this session of Congress.

Two major changes are proposed in the new measure. One would remove all limits on how long a patient could stay in a hospital or nursing home or on how many home-nursing visits he could receive after discharge. This change would vastly inflate the over-all cost of the program by encouraging lifelong stay in hospitals for ailing oldsters, whether or not there was any real need for such care. It would also cause a critical shortage both of hospital facilities and professional staff—at the expense of the genuinely sick.

The other major revision would make the patient pay a bigger part of his hospital bill unless he was close to the zero point in income. Those with the biggest incomes would pay the most, although they had already paid most in pre-retirement Social Security taxes; but even persons with incomes far below the Federal designated poverty level of $3,000 a year would be hurt.

Thus, an aged person with a $1,500 income would have to pay the first $80 of his hospital bill, as against the $40 that would be standard for everyone under the medicare program passed by the House. A $3,000 income would mean an individual obligation of $180, or four and one-half times the original level. For a $5,000 income the patient's cost would be $320, and for $10,000 it would be $670. The administrative problem for hospitals of trying to police incomes would be insuperable; the indignity to the aged would degrade the whole insurance concept.

The country will hope that the committee scraps its destructive proposal when it meets again Tuesday. Until Mr. Long pushed through his abortive revisions, the Senators had been doing a useful job of correcting technical flaws in the House bill. That bill still represents a sound foundation for a program the nation badly needs.—*The New York Times,* June 26, 1965. ◄

## From *The Journal* 50 Years Ago

The Indianapolis Medical Society will give a smoker for the members of the Indiana State Medical Association at the Claypool Hotel at 9 p.m. on Wednesday evening, September 22. It will be a stag affair and strictly informal. All members of the Association are cordially invited to be present .... On Thursday afternoon automobiles will be in waiting at the Claypool Hotel at 1:30 to take the visiting ladies on a ride about the city and end at the country home of Dr. and Mrs. David Ross, north of Broad Ripple, where light refreshments will be served.

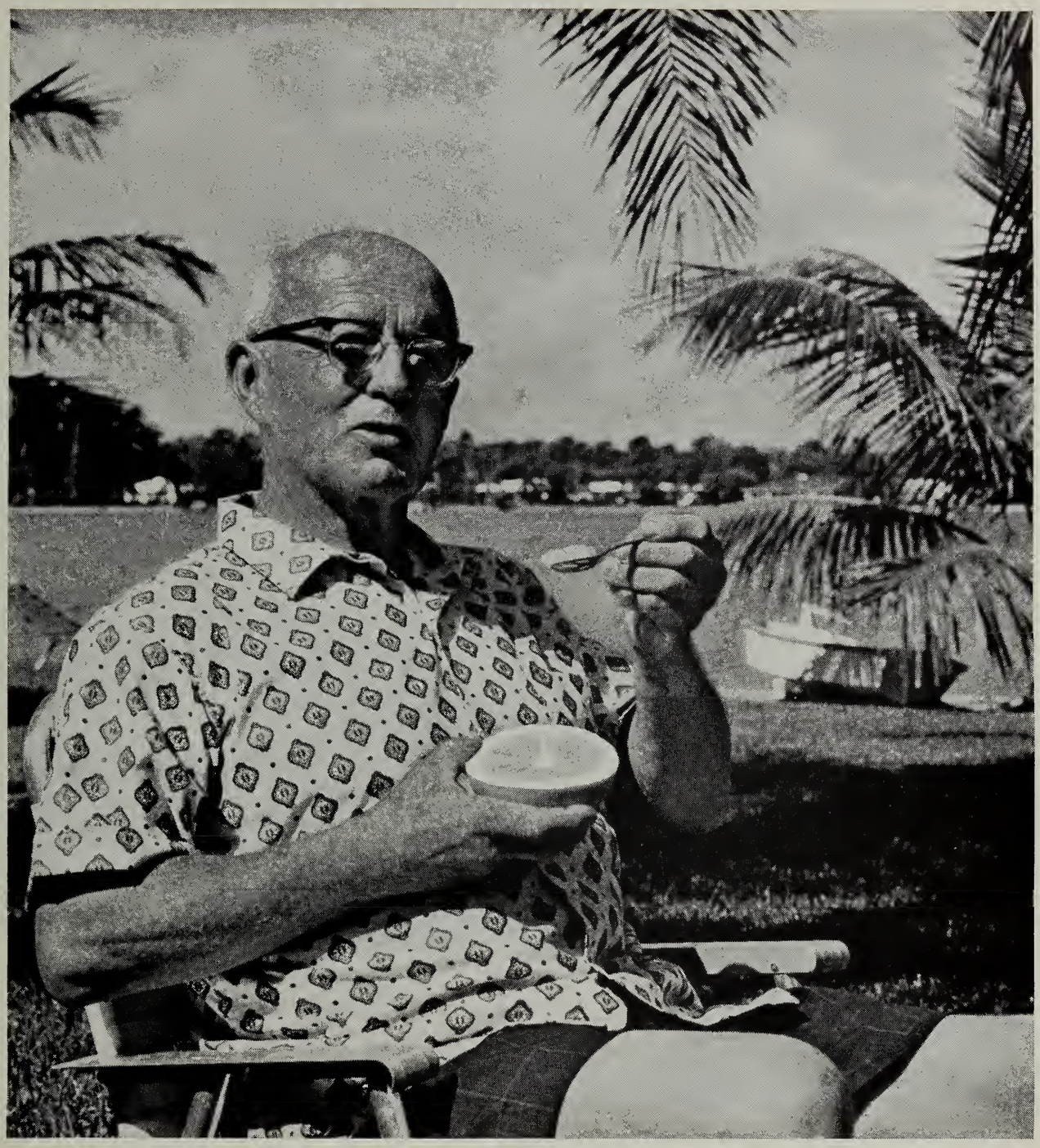
* * * *

The committee has submitted the following list of hotels and their rates, and urges that members make early reservations:

Claypool Hotel, European plan; rooms without bath $1.50 to $2 and $2.50 per day; rooms with bath, $2.50 to $3 and $3.50 per day.

Severin Hotel, European plan; rates $1.50 and up.

Denison Hotel, European plan, $1 to $4 per day; American plan $3 to $5 per day. . . . Committee on Convention Arrangements for 1915 Indianapolis Session, *JISMA,* September, 1915.



# The good life–just what the doctor ordered

Sea and sun are both in his doctor's orders – so is that grapefruit he's eating with such gusto. Citrus fruit is a wonderful way for this patient or any patient to get his daily quota of vitamin C . . . to enjoy something good to eat, tasty and satisfying but not rich.

Not all patients are so lucky as to have retired to Florida, where they can pick citrus fruit off their own trees. But any patient anywhere can get the same benefits of the natural vitamin C in Florida oranges, grapefruit, and tangerines . . . thanks to modern methods of processing fresh fruit. Whether it is frozen, canned, or in cartons, 98% of the vitamin C content of the fruit is preserved.

Grapefruit and other citrus fruits filled with vitamin C are valuable in the nutrition of every age group. Among the teen-agers, vitamin C is one of the two nutrients most often low in the diet. Infants, too, need generous amounts of vitamin C; and they will take it readily when it comes to them in the form of delicious orange juice.

When your patient chooses *Florida* citrus, he can be sure of getting fruit filled with natural goodness and of just the right sweetness. Florida citrus is unexcelled because a State commission watches over the entire Florida citrus crop to see that it meets the world's highest standards for fresh, frozen, canned, or cartoned citrus fruit.

© Florida Citrus Commission, Lakeland, Florida

# Letters to the editor

July 29, 1965

To the Editor:

I think the last issue of *The Journal* was perfect. It had a lot of information on a lot of topics. I especially liked the inclusion of Dr. Oliver's unusual experiences, and the Letters to the Editor.

I have an idea which I modestly think is a brilliant way to aid research and reduce reduplication and wasted money. Before beginning research on some problem, let a questionnaire be printed first in a magazine such as yours asking for information and theories from its thousands of readers. In all that vast, unshared, untapped storehouse of experience, there may well be the answer.

This could apply to other fields and professions too.

Yours truly,
A. A. HAMILTON, M.D.
Box 155
Vevay, Ind.

July 28, 1965

To the Editor:

I feel that the letter from Dr. James Keplinger* is deserving of an answer but not necessarily of approval.

I do not know the doctor, his specialty, if any, so most of my opinion must be based on deduction. I would feel in all probability the doctor is probably one of the surgical subspecialists, and the clearly expressed paranoid coloring frequently occurs in this group. As a senior and possibly senile citizen, I feel justified in pointing out some of the facts of life to the doctor.

*The Indiana State Medical Journal* has long been, and still is, one of the outstanding journals of the country. I think that some of this is due to the fact that it is not overloaded with medical and scientific articles. It is well known by all that 90% of published articles are not worth the printer's ink. They are legitimate advertising that brings the author's name to other medical men and are usually about par for the output of Madison Avenue.

If the doctor will only glance at the table of contents of some of the specialty magazines, he may find a title such as "Similar and Dissimilar Manifestations of Obsessive-Compulsive Neurosis in Monozygotic Twins." I am sure he will understand what I mean.

I also deduce that it is highly probable that the young doctor has a paper that has not been published as promptly as he wishes.

E. ROGERS SMITH, M.D.
722 Hume Mansur Bldg.,
Indianapolis, Ind.

**Editor's Note:**

**With all the discussion in the current Congress concerning the crash program on heart disease, cancer and stroke we think the letter printed below, addressed to the President by Dr. Amos Johnson, President of the American Academy of General Practice, is of interest.**

July 12, 1965

The President
The White House
Washington, D. C.

Mr. President:

As the elected president of the American Academy of General Practice, it is my honor and duty to represent some 29,000 family physicians of this nation. It is on their behalf that I am writing this letter about the report of your Commission on Heart Disease, Cancer, and Stroke and about some of the legislation which has

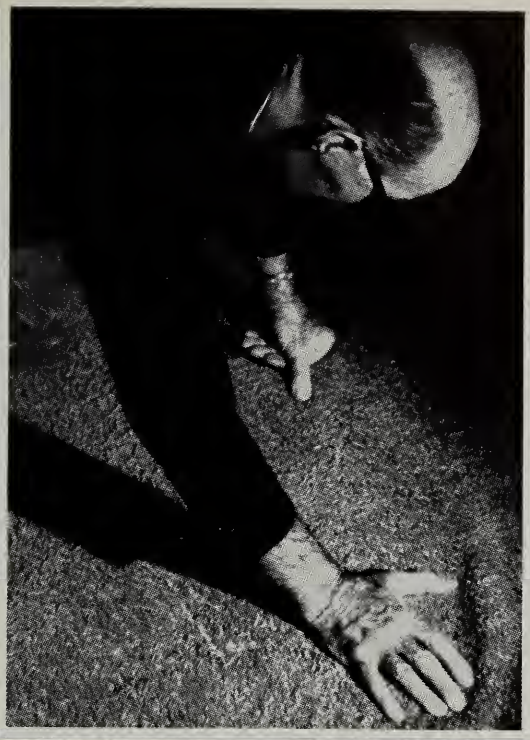
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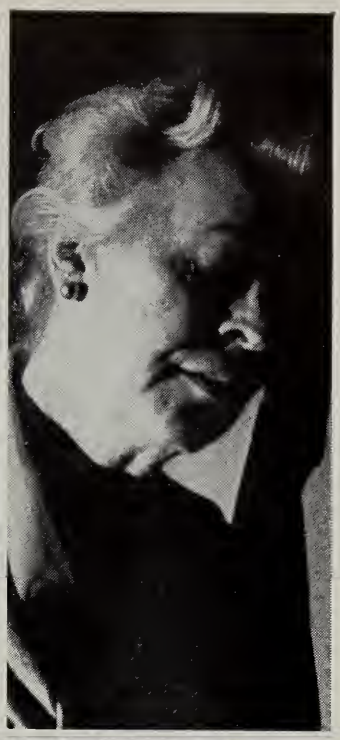
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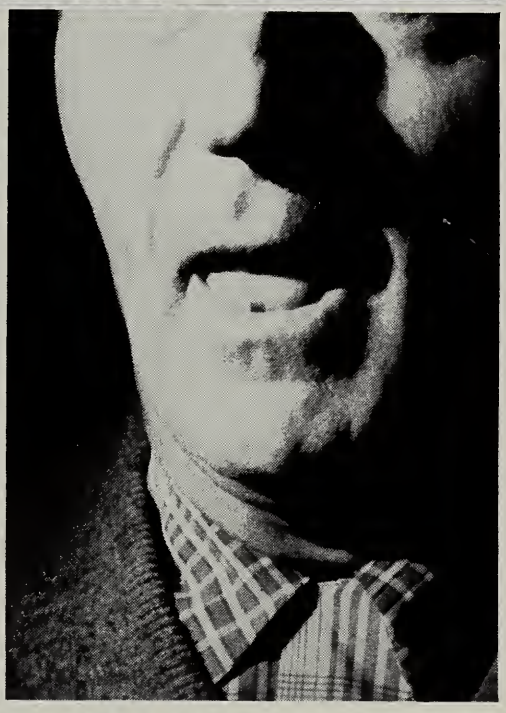
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**References:** (1) Abstract of Proceedings, Stroke Conference, Chicago (Feb. 14-16) 1963, prepared for use at National Stroke Congress, October 1964. (2) Blouin, L., and Overman, R. R.: Detailed reports in Mead Johnson Research Files.* (3) Gloning, K., and Klausberger, E. M.: Wien. klin. Wchnschr. **70**:145-149 (Feb.) 1958. (4) Whittier, J. R., and Dhrymiotis, A. D.: Angiology **13**:324-327 (July) 1962. (5) Horton, G. E., and Johnson, P. C., Jr.: Angiology **15**:70-74 (Feb.) 1964. (6) Whittier, J. R.: Angiology **15**:82-87 (Feb.) 1964. *Available upon request.

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been formulated to implement this proposed program.

Although the program has some good aspects, we believe it has some rather serious defects and omissions. These we would like to call to your attention, for it is only through expression of honest differences of opinion that we will make progress in areas such as this.

It is our belief that large regional centers such as proposed in Senate Bill 596 and HR 3140, and their counterparts, provide neither the most effective nor the most economical means of combating these illnesses. Many believe that our large complex specialty-segmented and isolated medical centers are increasingly providing less effective patient care.

Certainly, as is most of medical education presently, this program is unduly slanted toward remedial patient care. A program aimed toward producing an ample supply of well-trained family physicians oriented to health care (prevention and control, as well as remedial care and rehabilitation) could be productive of better health for Americans.

Certain implications in the report of the DeBakey Commission are objectionable to us for we do not believe they are borne out by the facts and figures quoted to this commission.

The first of these is the implication that mortality is lower and morbidity is reduced in heart disease, cancer, and stroke patients treated in large medical centers in comparison with those treated in smaller hospitals or even in their own homes. Those of us who are on the "firing line" of medical practice are daily required to think long, hard thoughts before we refer a patient from his local community to a large medical center where he might receive over-treatment which would be less beneficial than care under his family physician at home.

It is also implied that standardized care at a regional center would mean better care. We think you will find that there is much disagreement even among the medical academicians as to what constitutes the best

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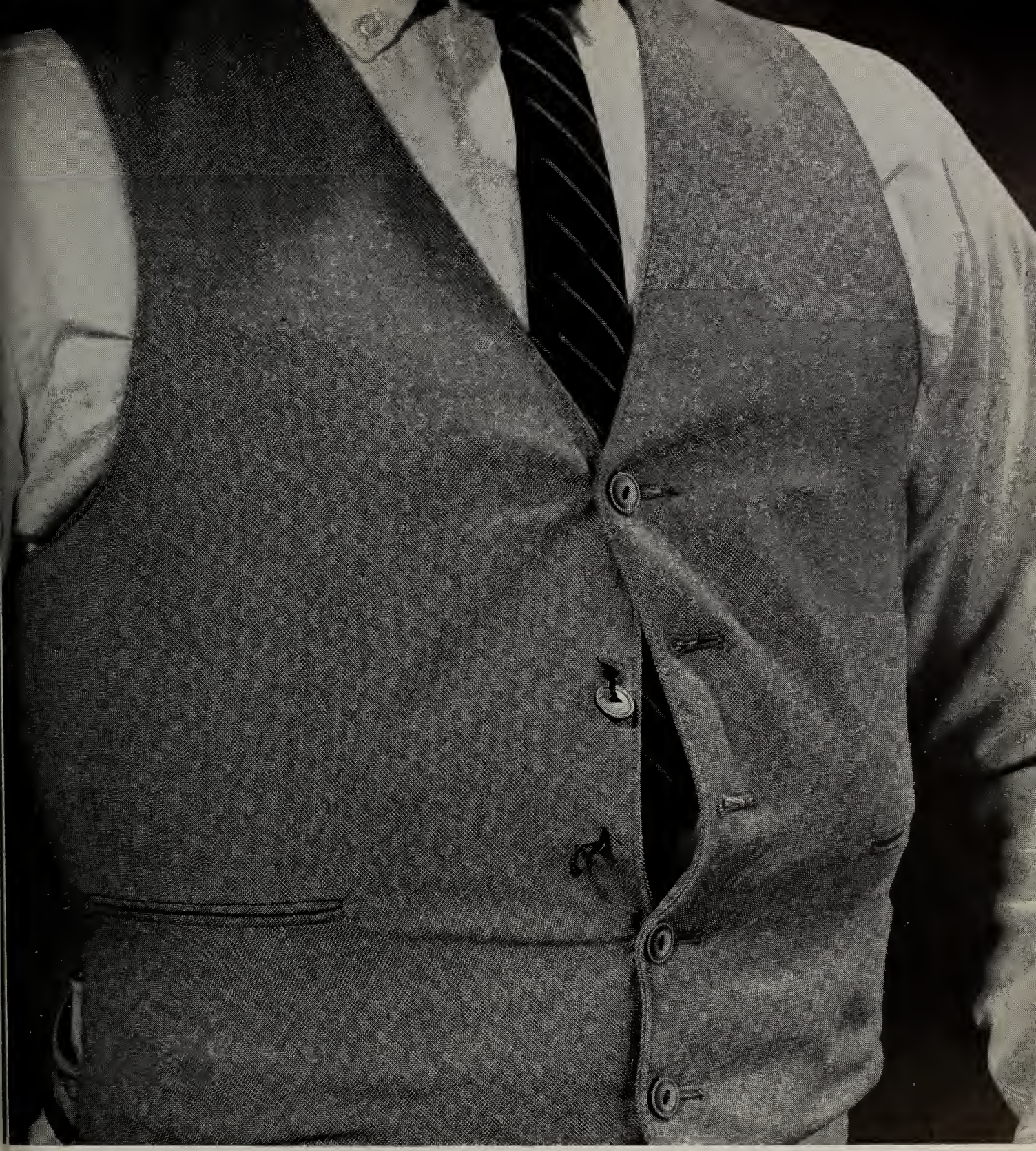
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care in each of these fields. For example, some treat with anticoagulants and some don't; some treat with radiation; some treat with surgery; some use surgical approaches for vascular conditions and some don't.

We also hasten to refute the implication that information on the latest advances in research and therapy is not being adequately disseminated to practicing physicians of the nation. Many postgraduate programs for practicing physicians are provided for this purpose. We call to your attention the fact that, although our organization is the only major medical organization which requires completion of a certain number of hours of postgraduate study periodically to maintain membership, thousands of courses are sponsored annually by medical schools, other medical organizations and divisions of the Public Health Service to bring the latest in medical developments to the practicing physicians.

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The Academy's membership together with other practicing physicians in this country probably take care of 95% of the people who are afflicted with these three illnesses. The commission which studied this problem, however, was made up almost entirely of men in academic medicine. Practicalities of the provision of medical care received little consideration in the formulation of this report.

This group, Mr. President, could hardly give a representative opinion on these problems. We believe, in fact, it has given opinions which are *not* representative of the majority of practicing physicians in this country. We believe that this report could have originated only in the minds of those who are quite far removed from the day-to-day problems of taking care of people who are sick.

This program as presented has a tremendous emotional appeal in its promise of reducing deaths due to these three causes. However, many deaths resulting from heart disease and stroke are abetted by the natural aging process and more extensive treatment of these patients at regional centers will not bring about a reduction in this death rate. We believe this report gives the public the erroneous impression that with the expenditure of considerable federal funds, a panacea can be purchased. This we know is not possible.

We do not think that increasingly large expenditures of federal funds can purchase answers to the problems of the etiology of cancer or arterial degeneration. We believe it would be more effective to concentrate available funds on well-planned and well-supervised research programs which can be staffed by qualified research personnel. Effective, productive medical research is not a commodity to be bought on today's open market at any price.

We need not more but better qualified medical research scientists. However, an even greater need is for more physicians in private practice who can provide comprehensive health care to all people as often as possible in their own environment.

Sincerely,
Amos N. Johnson, M.D.
Garland, N.C.

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 58 — September 1965 — Number 9

# Smoking Habits and Health in Indiana and Neighboring States*

E. CUYLER HAMMOND, Sc.D.
New York, N.Y.

THE INDIANA DIVISION of the American Cancer Society, together with 28 other divisions, is cooperating in a prospective epidemiological study aimed at identifying factors related to the occurrence of cancer and other diseases. Smoking is one of many environmental factors included in the investigation and we have recently published findings on the subject during the first 34 months of follow-up.[1] In this paper, we will present some of the findings in the Indiana segment of the study.

During the latter part of 1959 and early 1960, volunteer workers of the Indiana Division of the American Cancer Society enrolled 34,814 men and women, in a study area which encompassed 47 of the 92 counties of the state. The mean date of enrollment being November 21, 1959. Upon enrollment, each subject answered a detailed questionnaire covering such factors as family history, history of disease, physical complaints, education, occupational exposure, height, weight, exercise, diet and various habits. The subjects are traced once a year and are requested to fill out brief questionnaires once every two years. By the end of the third follow-up, 98.5% of the subjects were traced through September 30, 1962. When a death is reported, we request the Indiana Health Department to supply us with a copy of the death certificate; and when cancer is mentioned on the death certificate, we request the deceased's physician to supply additional information.

The Indiana portion of the report is confined to the records of 13,951 men between the ages of 40 and 89 who were traced through September 30, 1962. Of these 13,951 men, 590 (4.2%) were reported to have died; and we now have copies of the death certificate on 583 of them. Cancer was mentioned on 109 of the certificates and doctors have provided additional information on 97% of them.

## Physical Complaints

A list of various physical complaints was printed on the first questionnaire and the subject was asked to check "yes" or "no" after each of them to indicate whether or not he had the complaint "at present." Those who had a complaint were asked whether it was "slight," "moderate" or "severe." Of the 13,951 men between the ages of 40 and 89, 4,337 said that they were currently smoking 20 or more cigarettes a day and 3,118 said that they had never smoked regularly. Table 1 shows the number and percentage of these smokers who reported having various complaints and the percentage of non-smokers who reported complaints. The percentages for the non-smokers have been adjusted to the age dis-

* From the Indiana Division of the American Cancer Society and the Statistical Research Section of the Medical Affairs Department of the American Cancer Society, Inc.

**PHYSICAL COMPLAINTS REPORTED BY 4,337 INDIANA MEN WHO SMOKED 20 OR MORE CIGARETTES PER DAY AND BY 3,118 INDIANA MEN WHO NEVER SMOKED REGULARLY**

| Physical Complaint | Cigarette smokers with complaint | | Non-smokers with complaint | Ratio (b) ÷ (c) |
|---|---|---|---|---|
| | Number of Men (a) | Percent (b) | Percent (c) | (d) |
| Cough (slight, moderate, severe) | 2,474 | 57.0% | 14.9% | 3.83 |
| Cough (moderate or severe) | 1,198 | 27.6 | 5.0 | 5.52 |
| Shortness of breath (slight, moderate or severe) | 1,561 | 36.0 | 15.7 | 2.29 |
| Shortness of breath (moderate or severe) | 643 | 14.8 | 5.1 | 2.90 |
| Pain or discomfort in chest (slight, moderate or severe) | 775 | 17.9 | 11.9 | 1.50 |
| Pain or discomfort in chest (moderate or severe) | 284 | 6.5 | 3.7 | 1.76 |
| Loss of appetite | 279 | 6.4 | 2.0 | 3.20 |
| Loss of weight | 354 | 8.2 | 6.0 | 1.37 |
| Gain of weight | 164 | 3.8 | 3.2 | 1.19 |
| Nausea or vomiting | 237 | 5.5 | 3.8 | 1.45 |
| Hoarseness | 562 | 13.0 | 9.3 | 1.40 |
| Fatigue easily | 1,775 | 40.9 | 30.0 | 1.36 |
| Diarrhea | 267 | 6.2 | 4.9 | 1.27 |
| Pain in stomach | 686 | 15.8 | 12.4 | 1.27 |
| Indigestion | 1,161 | 26.8 | 21.7 | 1.24 |

TABLE 1

tribution of the cigarette smokers (this being necessary for comparability since the non-smokers tended to be older than the cigarette smokers).

Cough, shortness of breath and pain or discomfort in chest were all reported far more frequently by the cigarette smokers than by the non-smokers, the ratio being 3.83:1 for cough, 2.29:1 for shortness of breath and 1.50:1 for pain or discomfort in chest. Considering only subjects who reported these complaints to a moderate or severe degree, the ratios were 5.52:1 for cough, 2.90:1 for shortness of breath and 1.76:1 for pain or discomfort in chest. These findings are consistent with the findings in histologic studies of changes in lung tissue in relation to cigarette smoking.[2,3] Such studies have shown a high degree of association between cigarette smoking and: 1) hyperplasia and the occurrence of cells with atypical nuclei in bronchial epithelium 2) hyperactive glands in the walls of bronchial tubes and 3) changes in the lung parenchyma including rupturing of alveolar septums, fibrosis and thickening of the walls of arterioles and small arteries.

Loss of appetite was reported over three times as frequently by cigarette smokers as by non-smokers. One might expect this to be associated with loss of weight; and loss of weight during the preceding two years was reported somewhat more frequently by cigarette smokers than by non-smokers. However, gain of weight was also reported somewhat more frequently by cigarette smokers than by non-smokers. This suggests that fluctuations in weight may occur somewhat more frequently in cigarette smokers than in non-smokers.

A number of other physical complaints such as hoarseness, nausea or vomiting, pain in stomach, diarrhea, indigestion and a tendency to "fatigue easily" were also reported somewhat more frequently by cigarette smokers than by non-smokers. The picture in general indicates that cigarette smokers, as a group, tend to feel less physically fit than do non-smokers.

### Hospitalization

At the time of the second follow-up (approximately two years after the start of the study) surviving subjects were requested to fill out a second questionnaire, they were asked whether or not they had been hos-

pitalized since October 1, 1959 (the date the study was started). We assumed that all those who died had been hospitalized prior to death, this being true in the great majority of cases.

In Table 2, Indiana men aged 40 to 69 are classified in groups by their smoking habits as reported on the first questionnaire; and the percent hospitalized is shown for each of these groups. For comparability, the percentages have been standardized for age on the basis of the age distribution of all the men in the study.

Only 13.3% of the men who never smoked were hospitalized within this two year period while 17.0% of the men with a history of only cigarette smoking were hospitalized during the same period of time. Among current cigarette smokers, the risk of hospitalization increased with amount of smoking from 16.5% for those who smoked less than 20 cigarettes per day to 20.4% for those who smoked 40 or more cigarettes per day. The percent of men hospitalized was greatest among cigarette smokers who said that they inhaled deeply; and was greater among men who started to smoke cigarettes early in life than among those who started to smoke later in life.

**PERCENT OF MEN HOSPITALIZED BETWEEN START OF STUDY AND SECOND FOLLOW-UP (APPROXIMATELY TWO YEARS).**

| Smoking Habits | Percent Hospitalized |
|---|---|
| Never Smoked Regularly | 13.3% |
| Cigar, Pipe (no cigarettes) | 13.8 |
| Cigarette and other | 16.1 |
| Cigarette only | 17.0 |
| Current Cigarette Smoking* | 17.2 |
| Less than 20 a day | 16.5 |
| 20 — 39 a day | 17.1 |
| 40 + a day | 20.4 |
| Inhale none or slightly | 17.4 |
| Inhale moderately | 16.9 |
| Inhale deeply | 19.1 |
| Age Began Smoking: | |
| 25 or older | 15.4 |
| 20 — 24 | 16.2 |
| 15 — 19 | 17.2 |
| Before age 15 | 19.6 |

* Men with a history of only cigarette smoking who were currently smoking cigarettes at the time of enrollment.

TABLE 2

## Mortality

A statistically meaningful analysis of death rates in relation to smoking habits requires a large number of subjects. Therefore, we combined the Indiana segment of the study with the segments from four neighboring states, Ohio, Michigan, Illinois and Kentucky. In these states we enrolled and traced a total of 93,558 men in age group 40-89; and 4,086 of these died between the start of the study and September 30, 1962.

Table 3 shows the men classified by type of smoking (lifetime history). The figures under the heading "observed" are the actual number of deaths reported from the start of the study through September 30, 1962. Figures under the heading "expected" are the number of deaths which would have occurred if the age-specific death rates in each group had been the same as the age-specific death rates of men who never smoked regularly. In other words, the age-specific death rate of the non-smokers is taken as a standard for comparison. The mortality ratio is the observed number of deaths divided by the expected number of

**MORTALITY BY TYPE OF SMOKING (LIFETIME HISTORY)**

| Type of Smoking (Lifetime History) | Age 40 — 69 | | | | Age 70 — 89 | | | |
|---|---|---|---|---|---|---|---|---|
| | Number of Men | Number of Deaths | | Mortality Ratio | Number of Men | Number of Deaths | | Mortality Ratio |
| | | Observed | Expected | | | Observed | Expected | |
| Never Smoked Regularly | 17,989 | 446 | 446.0 | 1.00 | 2,601 | 411 | 411.0 | 1.00 |
| Pipe, Cigar Only | 9,293 | 282 | 271.4 | 1.04 | 2,012 | 300 | 320.8 | 0.94 |
| Cigarette and Other | 19,761 | 728 | 470.5 | 1.55 | 1,350 | 244 | 184.4 | 1.32 |
| Cigarette Only | 39,188 | 1,427 | 797.0 | 1.79 | 1,364 | 248 | 182.3 | 1.36 |
| Total | 86,231 | 2,883 | 1,984.9 | 1.45 | 7,327 | 1,203 | 1,098.5 | 1.10 |

TABLE 3

deaths. By definition, the mortality ratio of the non-smokers is 1.00.

Men with a history of only cigarette smoking had by far the highest death rates (as indicated by their high mortality ratios). In age group 40 to 69, the death rate of such cigarette smokers was 79% higher than the death rate of non-smokers (Figure 1). In age group 70-89 the death rate of such cigarette smokers was 36% higher than the death rate of non-smokers.

The death rate of men who smoked cigarettes and also smoked pipes or cigars (i.e., the "cigarette and other" group) was somewhat lower than the death rate of men who smoked cigarettes only. This is accounted for by the fact that men with mixed smoking habits tend to smoke fewer cigarettes per day and tend to inhale the smoke less deeply than do men who smoke only cigarettes.

The death rate of pipe and cigar smokers was only slightly higher than the death rate of non-smokers among men 40-69, and slightly lower in men 70-89. This appears to be due to the fact that the great majority of pipe and cigar smokers do not inhale the smoke or inhale it only to a slight degree.

Table 4 shows further details on current cigarette smokers (i.e., men who were

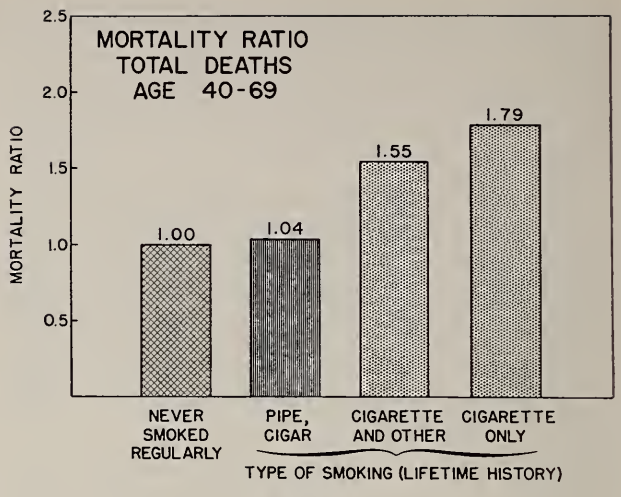



FIGURE 1

smoking cigarettes regularly at the time they enrolled in the study) with a history of only cigarette smoking. It is confined to men between the ages of 40 and 69 for the reason that there were relatively few such cigarette smokers among men in the older age groups. Figures for non-smokers are included to give a basis for comparison.

The mortality ratio was substantially higher among cigarette smokers who said they inhaled deeply than in those who said they did not inhale. The cigarette smokers who took up the habit before they reached their 20th birthday had higher death rates than did cigarette smokers who started the habit later in life.

**MORTALITY BY AMOUNT OF CIGARETTE SMOKING, DEGREE OF INHALATION AND AGE BEGAN CIGARETTE SMOKING (AGE GROUP 40 TO 69).**

| Current Cigarette Smoking | Number of Men | Number of Deaths Observed | Number of Deaths Expected | Mortality Ratio |
|---|---|---|---|---|
| 1 — 9 | 2,351 | 79 | 55.1 | 1.43 |
| 10 — 19 | 5,185 | 194 | 112.1 | 1.73 |
| 20 — 39 | 17,910 | 653 | 333.7 | 1.96 |
| 40 + | 3,810 | 151 | 63.7 | 2.37 |
| Degree of Inhalation | | | | |
| None | 1,791 | 58 | 48.6 | 1.19 |
| Slight | 3,932 | 178 | 91.1 | 1.95 |
| Moderate | 16,579 | 582 | 306.8 | 1.90 |
| Deep | 6,933 | 259 | 118.4 | 2.19 |
| Age Began Cigarette Smoking | | | | |
| 25 + | 2,523 | 77 | 60.0 | 1.28 |
| 20 — 24 | 6,928 | 202 | 134.3 | 1.50 |
| 15 — 19 | 15,593 | 603 | 285.1 | 2.12 |
| < 15 | 3,340 | 147 | 65.8 | 2.23 |
| Never Smoked Regularly | 17,989 | 446 | 446.0 | 1.00 |

TABLE 4

Death certificates indicated that coronary artery disease accounted for 1,894 (46.4%) of the 4,086 deaths. Deaths from this cause were highly associated with the smoking habits of men in age group 40 to 69 but less highly associated with the smoking habits of men in age group 70 to 89. In age group 40-69, the coronary artery disease mortality ratios were: 1.00 for men who never smoked, 0.91 for pipe and cigar smokers, 1.53 for men who smoked cigarettes and also smoked pipes or cigars and 1.74 for men who smoked only cigarettes. The corresponding mortality ratios for men in age group 70-89 were 1.00, 0.77, 1.45 and 1.37 respectively. Among cigarette smokers, the death rate for coronary artery disease was related to the degree of inhalation. For example, among cigarette smokers in age group 40-69, the mortality ratio was 1.17 for those who said that they did not inhale the smoke and 2.37 for those who said that they inhaled deeply.

Lung cancer accounted for the death of 170 men (143 in age group 40-69 and 27 in age group 70-89). All but six of these men were smokers (14 smoked only pipes or cigars and 150 had a history of regular cigarette smoking). The lung cancer death rate was eight times as high among men with a history of cigarette smoking as among men who never smoked; and the lung cancer death rates of cigarette smokers increased with amount of smoking.

Previous studies have shown a relationship between smoking habits and death rates from cancer of the buccal cavity, pharynx, larynx, esophagus and bladder. Cancer of these sites accounted for 66 deaths. All but six of these men were smokers (13 smoked only pipes or cigars, 17 smoked cigarettes and pipes or cigars and 30 smoked only cigarettes).

Emphysema was responsible for 47 deaths. None of these men had ever smoked regularly; two smoked only pipes or cigars; and 45 had a history of cigarette smoking.

## Conclusions

The findings in the study on men in Indiana and neighboring states are in good agreement with previous prospective epidemiological studies on smoking in relation to health.[4-9] The epidemiological evidence together with evidence from clinical, histologic and experimental studies indicate that cigarette smoking is a serious hazard to health.[10,11,12]


## Acknowledgments

This study was made possible by the cooperation of the men who volunteered as subjects; volunteer workers of the American Cancer Society who enrolled and traced the subjects; the Health Departments of Indiana and the other states included in this study that provided copies of death certificates, and many physicians who provided additional information relating to deaths from cancer.


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**(Requests for reprints should be sent to: American Cancer Society, Indiana Division, Inc., 445 N. Pennsylvania St., Indianapolis, Indiana.)**

## Intermittent Cerebral Insufficiency

This case report presents a sequence of four identical episodes of intermittent cerebral insufficiency in a 78-year-old white male. All attacks occurred within one year and clinical recovery was complete between attacks, except for the last one.

The first two attacks took place in the patient's home state of Ohio and the latter two whilst visiting relatives in New York City.

A right stellate ganglion block was performed after each episode and each time produced a truly dramatic clinical recovery.

The fourth episode took place while the patient was sitting quietly at a relative's home. He was admitted to the Cumberland Hospital within 40 minutes. At the time of admission he was comatose, drenched with sweat and had a somewhat cyanotic skin. The heart had a regular sinus rhythm and was unremarkable except for the tachycardia. There were a few basal rales. Tonic and clonic twitchings of the left extremities were present.

As pulmonary edema was becoming a threat, emergency intubation was carried out. Rapid intravenous digitalization was accomplished and the airway was kept free by suction. Again, a right stellate ganglion block was performed.

After two days a slow improvement was apparent. The seizures subsided and the patient began to regain consciousness. A second right stellate ganglion block resulted in spectacular mental clearing. The neurological pattern gave the impression that this fourth episode would clear as completely as the previous three.

During the night however, the patient developed a temperature of 102° F rectally; because he took fluids and made no complaints, no doctor was called. At 5 a.m., the nurse noted that he was "in distress" and he died shortly afterwards.

Autopsy showed an occluding soft red thrombus in the petrous portion of the right internal carotid artery. In addition to the expected findings consistent with his cerebrovascular disease there was generalized moderate arteriosclerosis, left ventricular hypertrophy and slight nephrosclerosis. Other findings included incipient bronchopneumonia and glandular hyperplasia of the prostate.

The patient's death was sudden and unexpected and the autopsy failed to define the precise cause. Might it have been due to the three degree temperature rise six hours prior to death which may have produced a 20% additional deficit that made the difference between tolerable depression of cerebral circulation and irreversible lethal ischemia?

If the temperature rise was of such importance, what caused it, was it the incipient bronchopneumonia or the subsiding cystitis? Was it the recent small cerebral infarcts?

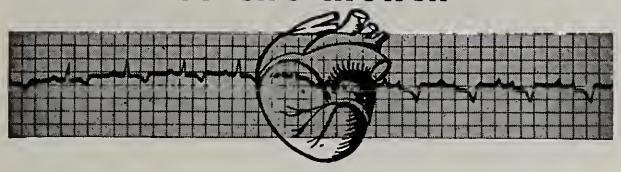
It is not clear whether the occluding thrombus in the siphon of the right internal carotid artery was the precipitating cause of death or whether it was merely an agonal event.

The stellate ganglion blocks performed on this patient produced dramatic clinical improvement; would a surgical denervation after the third episode have prevented the fourth and fatal attack?

Abstracted from a paper by Arnold Lieberman, M.D., New York, read at a symposium presented at the Syosset Hospital, Syosset, Long Island, N.Y. in November, 1963.

Published in *Geriatrics*, Vol. 20, pp. 213-218, March, 1965.

# Electrocardiogram of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Ventricular Standstill due to Ventricular Premature Beats*

*CHARLES FISCH, M.D.*
*Indianapolis*

STOKES-ADAMS disease is due to cerebral symptoms secondary to insufficient cardiac output. The spectrum of CNS symptoms may vary from giddiness to actual seizures, depending on duration of cerebral hypoxia. The mechanisms underlying the decreased cardiac output are (1) ventricular standstill, (2) ventricular tachycardia or fibrillation and (3) slow ventricular rate. The ventricular standstill may be secondary to atrial arrest or due to A-V block with ventricular arrest only. Figure 1 shows an unusual mechanism of ventricular arrest which resulted in Stokes-Adams disease. The dominant rhythm is normal sinus with a P-R interval of 0.20 seconds. Following the ventricular premature beat, five consecutive P waves fail to conduct, with ventricular standstill lasting 5.6 seconds. The resumption of the normal rhythm commences with an A-V nodal escape. This is suggested by the rather aberrant appearance of the first QRS following the standstill.

The mechanism of failure of A-V conduction following the V.P.S. is of interest. The V.P.S. delays the conduction of the P wave through the A-V node to such an extent that the next P wave finds the A-V node partially refractory, conducts slowly in a decremental fashion and fails to excite the ventricle. This delay of conduction of the first blocked P wave sets the chain which interferes with transmission of five subsequent P waves. The A-V nodal escape beat blocks the P wave high in the A-V node and allows for a normal recovery of the transmission system. The P wave that follows finds the A-V node completely recovered and arrives in the ventricle after a normal P-R interval. ◄

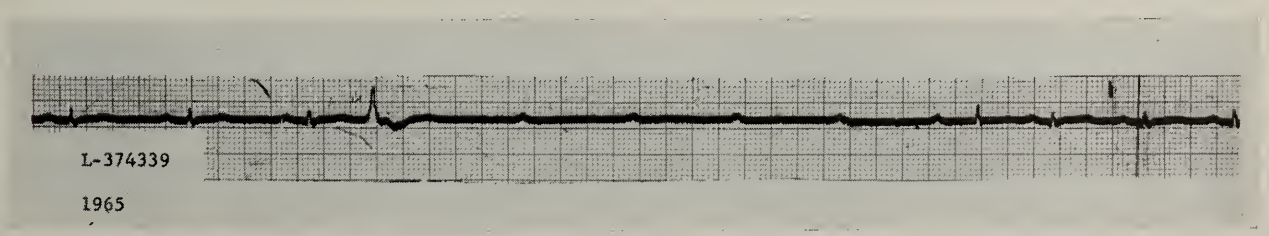



FIGURE 1

**THIS FIGURE** shows ventricular standstill following ventricular premature systole which is terminated by an A-V nodal escape.

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Food and Vegetable Bezoar in the Stomach

ERICH K. LANG, M.D.*
*Indianapolis*

A 72-YEAR-OLD white male was admitted to Methodist Hospital with upper gastrointestinal complaints. The patient related that indigestion and ill defined stomach pains had plagued him for the past nine months. The symptoms did not appear to be related to food intake nor could they be alleviated by alkali or food.

An upper GI series was performed and a huge filling defect was demonstrated in the stomach. It was felt that this defect was secondary to retained food particles, although the patient allegedly had been kept "NPO" for the past eight hours. The pyloric canal and the duodenal bulb were entirely unremarkable and barium passed into the duodenal bulb without delay.

The upper GI series was repeated in two days. The patient was again carefully prepared for the examination. However, huge filling defects were again demonstrated in the stomach. These defects appeared to be freely mobile and the question of a bezoar or an intragastric tumor on a pedicle was raised.

The patient was then placed on continued suction for 48 hours, and a third upper GI series was carried out. A multinodular filling defect was again readily demonstrable. The defect was freely mobile and was estimated to be the size of an orange. The masses could be moved about with the compression cone, but would not change their relationship to each other. The diagnosis of a bezoar was hence suggested. An exploration was carried out. As soon as the stomach was opened, a huge multinodular food bezoar containing vegetable fibers was readily demonstrated. The bezoar filled the entire fundus, the angle segment of the stomach and extended into the gastric antrum. The concretion was removed. Microscopic examination revealed the presence of vegetable fibers, some of which might have been of chewing tobacco etiology. Persimmon fiber components could not be identified. Gastric analysis was essentially normal.

* Department of Radiology, Methodist Hospital, Indianapolis.

## Comments

Food bezoars are considered extremely rare and are felt to be associated with either a definite gastric malfunction and obstruction or to be caused by habitual ingestion of undigestible components, such as hair and persimmons. Hair bezoars commonly occur in inmates of mental hospitals, while persimmon bezoars show a geographical predominance in the midwest. The diagnosis of a bezoar is usually readily established by successive upper GI series after meticulous preparation of the patient. The preparation should include gastric lavage. Care should be exercised with the use of the gastric suction tube, since friable intragastric pedunculated tumors which present in a similiar fashion may fragment, causing massive gastric hemorrhage. ◄

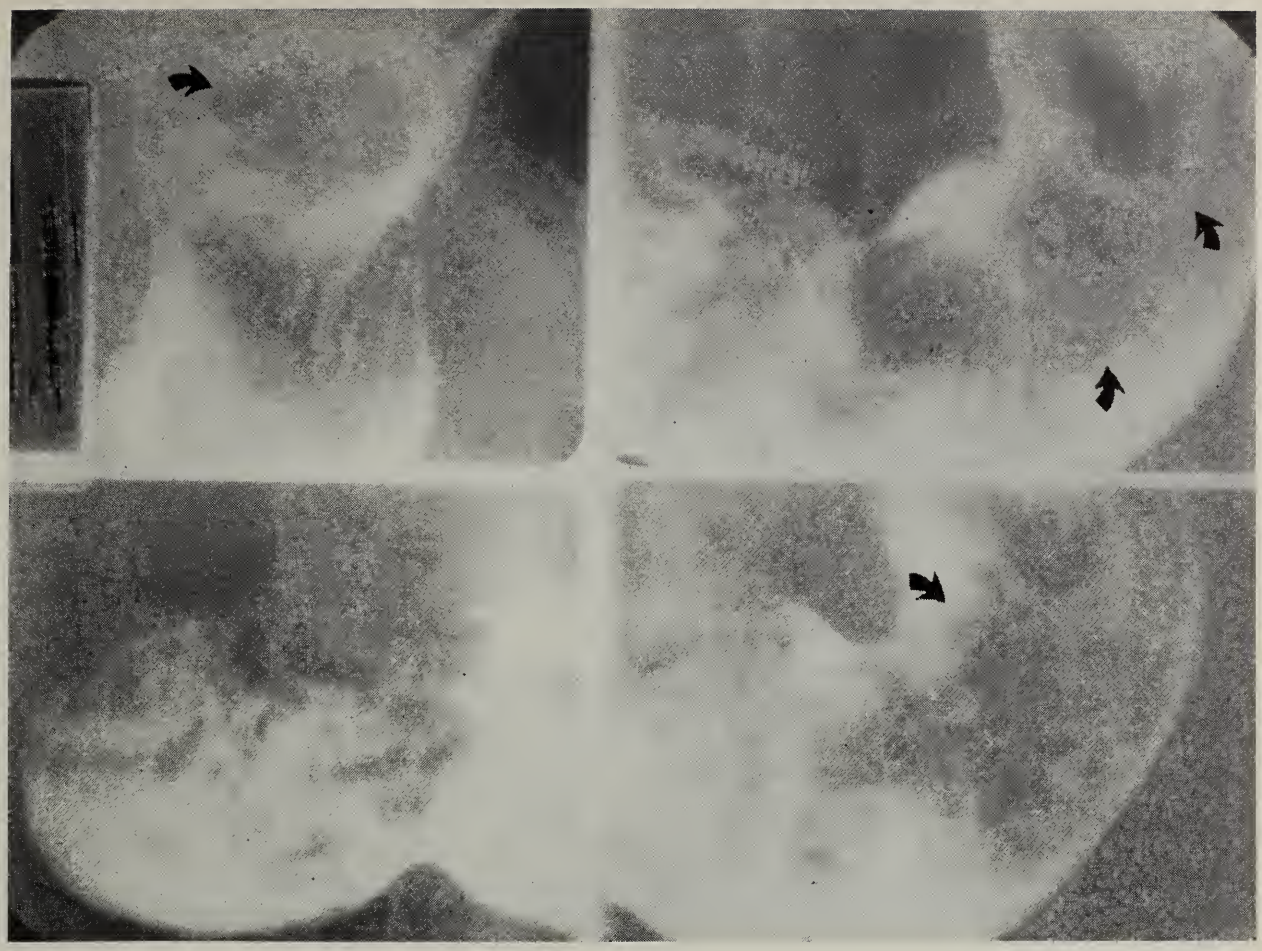


**FIGURE 1**

**NOTE the huge multinodular intragastric filling defects extending through the main segment of the stomach, the fundus segment and into the gastric antrum. Serial films with changing pressure on the compression cone failed to show separation of these filling defects.**

# LABORATORY MEDICINE

This page reviews established or relatively new but reliable laboratory procedures for physicians in general. It is not designed for specialists and laboratory personnel who would desire more technical information.

# Radioisotope Scanning (Part 2)

WEI-PING LOH, M.D.*
Gary

LUNG SCAN is generally performed with macroaggregate radioiodinated albumin which lodges quickly in the arteriolar bed of the lung. The small quantity of the macroaggregate albumin injected causes no difficulty in patients and the radiation dose to the patient is less than that given with the standard x-ray. The lung scan has the following uses:

1. Early detection and evaluation of pulmonary embolism and infarction. Detection by this method is generally much earlier than that by a standard x-ray procedure which requires 48-72 hours to show any diagnostic changes.
2. Detection and evaluation of tumors which interfere with the pulmonary blood supply.
3. Detection of other lesions causing vascular occlusion and determination of the degree of such occlusions.
4. Differentiation of focal from diffuse pulmonary diseases, e.g. cysts, bullae, massive atelectasis, fibrosis and pneumonia.
5. Evaluation and management of congenital heart disease.
6. Evaluation of patients before surgery.
7. Simultaneous liver and spleen scan is possible in this procedure 20-30 minutes after lodging of the macroaggregate radioiodinated albumin in the lungs.

* Chief Pathologist, Methodist Hospital of Gary, Inc.; Asst. Professor of Pathology, Chicago Medical School.

### Spleen Scan

A properly performed spleen scan, utilizing 51-Cr or 197-Hg, has the following uses:

1. Accurate estimation of the size, shape and position of the spleen. Displacement and repositioning of the spleen by malignant processes can also be detected.
2. Evaluation of a left upper quadrant mass.
3. Demonstration of a spleen which cannot be visualized by x-ray.
4. Detection and evaluation of splenic anomalies, such as ectopia, accessory spleen, agenesis, etc.
5. Demarcation of the spleen for accurate puncture site.
6. Study of red cell sequestration and hypersplenism.
7. Study of other splenic lesions, such as abscesses and infarcts.

### Bone Scan

Bone scan is useful in the localization of metastatic tumors and in the determination of benign and malignant lesions. We use strontium-85 and lately strontium-85m. Strontium-90 and strontium-89 can also be used in the procedure. Strontium localizes around the area of tumefaction where there is osteoblastic activity or new bone formation. Another technic is to use mercury-197 which localizes in the tumor cells. The combined use of both strontium and mercury has proven to be of greater value. All bone scans are done approximately 48 and

72 hours post-administration of the radioisotope. The uses of bone scan may be summarized as follows:

1. Detection and localization of metastatic tumors, particularly those coming from the prostate and breast. Metastasis to bone is next only to metastases to lymph nodes and lungs. Approximately 85% of carcinoma patients show bone metastases at the time of their death. This radioisotope procedure is more sensitive and more accurate than ordinary x-ray studies in detection of the metastatic lesions.
2. Differentiation between benign and malignant tumors.
3. Evaluation of osteomyelitis.
4. Evaluation of Paget's disease and other bone lesions.

### Pancreas Scan

Pancreas scanning has a history of only two and one half years. It is a little complicated technically and needs proper instrumentation. Selenomethionine-Se75 is the radioisotope utilized, because this material localizes with some specificity in the pancreatic tissue. Pancreatic carcinoma and areas of pancreatitis do not concentrate the material well. Scannings of the pancreatic bed are done at 30 minutes, two hours, four hours and 24 hours following administration of the radioactive material. This procedure holds promise in the following areas:

1. Early detection and localization of pancreatic carcinoma. It is claimed that this procedure is more sensitive than upper gastrointestinal x-ray studies and can detect a carcinoma nodule as small as two cm.
2. Diagnosis of pancreatitis, particularly chronic pancreatitis. It is claimed that the diagnosis of pancreatitis can be made much more readily by radioisotope scanning than by the standard laboratory evaluation of the pancreas which is positive in only 50% of the cases of proven pancreatitis.
3. Detection of pancreatic adenoma.
4. Evaluation of other conditions, such as penetrating peptic ulcer and diabetes.

### Parathyroid Scan

Parathyroid scan is a new procedure and is still an experimental evaluation. The small size and deep location of the parathyroid glands and the technical difficulties are a few of the problems commonly encountered. We use selenomethionine-Se75 in the procedure. The parathyroid uses methionine as a metabolite and when enlarged may be visualized by the scanning procedure. Parathyroid scan has value in the detection of parathyroid adenoma and parathyroid hyperplasia. The parathyroid localization has aided the surgical approach tremendously.

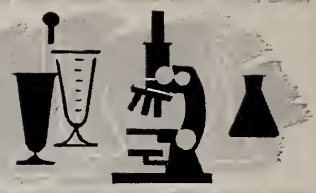
### Tumor Localization By Scanning

Other than detection and localization of tumors in the specific organs aforementioned, tumor localization by scanning is still somewhat investigational. It has been demonstrated that Hg-labeled Neohydrin enters and remains in tissues that have undergone carcinomatous change. This is also true of the lymphoma group of tumors and malignant tumors in vulva and nasopharynx.

The main benign pathology that competes for mercury localization is granulomatous lesion. As a matter of fact, granulomatous tissues, such as those of histoplasmosis or tuberculosis, are more avid for mercury than the carcinomatous tissue itself. Benign lesions, such as diverticulitis, will not concentrate the mercury. The scanning procedure is done 24 to 48 hours following administration of the radioisotope as it is best done when the blood has cleared the radioisotope. This procedure shows much promise and is expected to be of even greater value in the near future. ◄

# Path-finder

PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



**This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.**

# *Differential Diagnosis of the Month:* ABNORMAL PROTEINS

*KENNETH L. SCHERMER, M.D.**
*Indianapolis*

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|---|---|
| *Clinical data:* | An 84-year-old female had had severe left lower quadrant and back pain not relieved by Demerol for a one-day period. |
| *Physical examination:* | Thin, pale, dehydrated, chronically and acutely ill woman. Left breast surgically absent. Liver palpable 5cm. below the right costal margin. |
| *Laboratory data:* | Hemoglobin 7.8 gms., hematocrit 22, red blood cell count 2.1 million, white blood cell count 4,800. Differential — 87% polys (80% segmented, 17% bands, and 3% metamyelocytes), 8% small lymphocytes, 5% large lymphocytes and two nucleated red cells/100 white cells. Smear revealed platelets depressed and many cells resembling abnormal plasma cells.<br>Urine — persistent presence of substantial quantities of albumin. Bence Jones protein negative. BUN 26 mgs.%, Van den Bergh normal, total protein 7.96, albumin 5.78, globulin 2.18 with a 2.6 to 1 A/G ratio. Prothrombin time was 17.3 sec. or 52%, platelets .30 Vol. % and reticulocyte count 2.2% |
| *Consultation note:* | The pathologist was consulted because of the anemia, the many unusual cells resembling abnormal plasma cells and because of the increased A/G ratio. In view of these findings, the pathologist recommended bone marrow examination and serum electrophoresis. The bone marrow examination was considered consistent with the diagnosis of multiple myeloma. The serum protein electrophoresis revealed an abnormal protein in the gamma range. Because of the presence of this abnormal protein the Ouchterlony technic was used in an attempt to definitely identify the increased immunoglobulin. |

* Pathology resident, Department of Pathology, Methodist Hospital Graduate Medical Center, Indianapolis.

| | |
|---|---|
| *Interpretation:* | The Ouchterlony technic uses the principles of immunological precipitation reactions and kinetic diffusion. Three classes of human serum gamma globulins (immunoglobulins) can be recognized. They are: 7S $\alpha$ globulin, $B_{2A}$ globulin and $\alpha_1$ macroglobulin. The newer nomenclature uses the term "immunoglobulin G" for the 7S $\alpha$ which is usually increased in multiple myeloma, "immunoglobulin A" for the $Beta_{2A}$ globulin, and "immunoglobulin M" for the macroglobulin. Using the above described technic, the patient was found to have a positive immunological precipitation reaction between her serum and immunoglobulin G, thus substantiating the diagnosis of multiple myeloma. This technic has been found useful in identifying myeloma protein, in differentiating types of myeloma and macroglobulinemia, and in some neoplastic conditions in which the marrow aspirate is not diagnostic. |

## "Hot Line" for Drug Reactions

No responsible person can quarrel with the vast communications network set up throughout the world to exchange information on the side-effects of drugs. But this necessarily imposes the obligation on observers to be reasonably certain there is a fire before pulling this world-wide alarm system. A drug's side-effects should be measured against the good it does, else the benefits of therapeutic advances are nullified.

Let us remember that illness itself creates adverse manifestations, sometimes unexpected and bizarre. To assume that all of the patient's complaints and distress are due to an administered drug can be the worst kind of *post hoc, ergo propter hoc* reasoning, serving only to damage the good name of a drug and perhaps cause its withdrawal.—Theodore G. Klumpp, M.D., in *Massachusetts Physician* (23:208), June-July, 1965.

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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# I.U. Open House Scheduled

INDIANA UNIVERSITY School of Medicine will hold Open House to all physicians on Wednesday morning, October 13, during the annual convention of the Indiana State Medical Association.

Beginning at 8:30, buses will leave the Murat Temple at 15-minute intervals. Stops will be made at several locations on the medical center campus. Visitors may visit any one or all of the laboratories, tour areas of interest, meet faculty members and students, visit with Dean Glenn W. Irwin, Jr., and return to the Murat Temple on a subsequent bus.

Special preparations have been made to greet, direct and inform all those who are able to make the trip. A hearty welcome is assured for members of the Indiana State Medical Association and for our colleagues of the Congress on Occupational Health of the American Medical Association who wish to make or renew acquaintanceship with the medical school.

# 300,000 Children Poisoned Annually

CHILDREN are incredibly curious, fantastically ingenious in methods of satisfying their curiosity and will eat or drink anything. They may all be related to Christopher Columbus, or at least are endowed with the true explorer's intrepidity and resourcefulness in their search through the home for items of interest.

Modern homes are literally loaded with dangerous substances, all of which are attractive prizes for small and fragile explorers. And most of them are deadly dangerous. The Health Insurance Institute estimates from National Health Survey statistics that more than 300,000 nippers, four years of age and under, will be accidentally poisoned this year.

It takes a constantly alert and resourceful adult to safeguard the poisonous substances that abound in the home. In fact one adult per home is not enough. It takes the combined efforts and lots of cooperation of all the adults to maintain separation of a child or children from ingestible harm.

At one time there was a rule to the effect that poisons should not be placed in a container, such as a soft drink bottle, which usually contains potable food or beverage.

While this rule is not a bad one, it now appears to be not too effective, since children have been reported to have ingested the entire contents of the original containers of such liquids as kerosene. (They won't eat their spinach but love their kerosene.)

County-wide public education campaigns for the prevention of child poisoning would be a good project for every county medical society in the country; 300,000 accidents, all of which with proper care are preventable, are too many.

All drugs and household chemicals should be stored out of reach of children, or should be securely locked up, or both. Old medicine should periodically be discarded by flushing down the drain. Children should be told that aspirin is medicine, not "candy." All medicine should be administered with the lights on, never in the dark.

The layman should be taught that children who have swallowed kerosene or any substance containing lye should *not* be made to vomit. Everyone should be alerted to call the doctor or the nearest poison control center in case of accidental poisoning.

## *Guest Editorials*

# *Are You A Promoter?*

IF YOU have treated one case of gonorrhea or syphilis in your private practice and have not reported it to your local health officer for investigation of contacts, you are a promoter. You have not done your duty as a true physician. You could even be a promoter of an epidemic of either of the two diseases in your community.

Those of you who have never reported a case to be investigated for contacts may be assured that tact, discretion and confidential means are used throughout. No so-called "police methods" are used. It is only through establishing confidence between the trained investigator and the one referred, that real epidemiological work and results can be obtained. It works. Try it.

A superficial survey of most any of the general medical publications shows that they have certainly brought the practitioner's attention to the marked increase in venereal disease in the past few years. Such warning articles have been published repeatedly. Not only has the increase in venereal disease been noted in the United States but throughout the world, as evidenced by excerpts from foreign publications.

Even without exact statistics, the trend can be definitely established. Unfortunately the available figures have shown the increase definitely to be in the younger aged groups. Roughly calculated, 50% of the gonorrhea is estimated to be in females under 19 years old and 83% of all cases of that disease to be in individuals under 24 years of age.

Syphilis has also increased throughout the world but fortunately not to the extent of gonorrhea. The young adult and teenager, along with homosexuals, have accounted for the rise in the figures.

Yes, the treatment of the two most common venereal diseases has changed greatly but the method of transmission has not.

What can be done to check the progress of these infections? Treatment in the overall picture is satisfactory. The weak link, or whatever one wants to term it, is the medical profession.

Why be so pure and holy about reporting cancer cases simply because no sex is in the picture and so reluctant and non law-abiding in not reporting venereal cases? Yes, by reporting cases for investigation you might save one of "your kids" from a "spot" of venereal disease some day.

Promote the health of your community in the way you know it should be done.—S.R.M.

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For further emphasis on this subject see: *JAMA* 193:1, pp. 13, 61, 1965.

## *Sechswockenkrankheit*

NO, IT'S NOT a German delicacy of Thüringen sausage and potato pancakes, but it is German and a matter of serious concern in the booming economy of the Bonn republic. Literally, *Sechswockenkrankheit* means "the six weeks sickness." Industrial workers under Germany's extensive social welfare and state medicine program are its victims, but employers suffer, too.

Any West German worker who becomes ill may be indisposed for as long as six weeks and still receive his full pay and keep his job. If the sickness lasts beyond this period, the worker becomes unemployed, and the government pays his full salary for 26 weeks. Of course, the socialized medical program underwrites his care.

There is an amazing tendency, according to reports from West Germany, for almost any illness to last precisely six weeks. So ingrained has welfarism become that many German physicians soberly certify that the patient will be ill for exactly six weeks. Says the Insurance Economics Society of America, commenting on this state of affairs: "Any German citizen who balks at such paid vacations is likely to be regarded as slightly addled," pointing out that even the physicians cheerfully accept fees for care over the entire six weeks' period.

Dependency disease is virulent, and it seems to reach pandemic proportion in the welfare state. In fact, a mere six weeks' episode may soon be properly regarded as a light case.—R.B.K.—Reprinted from *The Journal of the Mississippi State Medical Association,* August, 1965, p. 331.

## Editorial Notes ...

**The price of drugs is decreasing while almost everything else is going up.** The Wholesale Price Index for Ethical Pharmaceuticals fell during 1964 from 86.2 to 86.0. This was the sixth consecutive yearly decline. The index was originated in 1949 at an arbitrary level of 100. While ethical drug prices have fallen by 14%, all wholesale prices have risen more than 20%.

**The National Aeronautics and Space Administration (NASA) has accomplished what might be called the natural synthesis of basic organic chemicals.** The five DNA-RNA building blocks, known as nucleotides, have formed without outside assistance, by exposing ammonia, methane and water to ultraviolet radiation in the presence of heat, electrical discharges (lightning) and radioactivity. These are the elemental chemicals and the laboratory conditions duplicated those which are supposed to have existed on the earth from three to four and one-half billion years ago. The last step in forming a nucleotide is the incorporation of phosphate. This proved to be the simplest step of all; addition of a phosphate salt at a temperature of 180°F was sufficient.

**Bern B. Grubb, pharmacist extraordinary from Logansport, has been cited by the Pharmaceutical Manufacturers Association for a life-saving and highly practical invention.** Mr. Grubb, now 90 years old, has in a busy lifetime been a retail pharmacist, president of a pharmaceutical manufacturing firm, a state legislator and hospital pharmacist. He emerged from retirement at the age of 77 to serve as Chief Pharmacist for the Logansport State Hospital. He devised a combination litter, cot, operating table and recovery bed to facilitate transportation of critical patients between the widely scattered buildings, 40 in number, of the Logansport hospital. Mr. Grubb has been retired from full-time work for four years. Spends his time keeping up-to-date in pharmacy and works part-time at a local pharmacy.

**The Veterans Administration is caring for twice as many mentally ill patients as it did 15 years ago, and has not increased the number of hospital beds devoted to such patients.** Tranquilizers and psychic energizers have made the difference, together with more efficient use of hospital facilities and the rehabilitation of the mentally ill by post-hospital care.

**More knowledge of inner ear disease is needed to solve the problems of deafness.** The immense value of a detailed study of the inner ear has lead to the custom of bequeathing temporal bones to the Deafness Research Foundation. The donor completes a pledge form and arranges for his physician to release his medical and hearing history after his death. No external disfigurement is involved in the removal and the cost of removal is borne by the Foundation. Normal ear structures are not needed. Temporal bones of those who have ear disorders and especially those who have undergone inner ear surgical procedures are vitally needed for research.

**Twelve blood chemistry determinations may be made automatically by a new analyzer using a small sample of blood.** The new VA hospital at Cleveland is using such an auto-analyzer which was developed by VA's chief biochemist, Dr. Leonard T. Skeggs. Serum calcium, carbon dioxide content, chloride, albumin, alkaline phosphatase, total protein, bilirubin, glucose, sodium, potassium, transaminase and urea nitrogen are measured and recorded automatically. Dr. Skeggs predicts the time when a 50-test machine will be devised.

**Hospital costs reached a new high in 1964, $41.58 per day for non-federal short term general and special hospitals, an increase of 6.9% over 1963.** The cost per day varies by regions of the U. S., from $54.28 (Pacific) to $34.31 (East South Central). Indiana is in the region which almost duplicates the national average. As in the past, most of the increase was due to increase in the payroll. In the last year, 47,000 new full-time personnel were employed in the hospitals. ◄

## About Our Cover

This issue of *The Journal* brings you all of the details of the 116th annual convention of the Indiana State Medical Association.

This year, though, there is a difference. The annual convention is being held in conjunction with the Congress on Occupational Health of the American Medical Association.

By checking the program now, you will be able to note the meetings, seminars, films and special scientific sessions you want to be sure to attend. A preview also is included of the fine array of technical and scientific exhibits that will be displayed to show you what is new in medicine.

An added attraction this year are the bus tours of the Indiana University Medical Center. Usual features include section meetings, continuous movies, scientific meetings, Clinical-Pathological Conference, the Fireside Conferences, the Medical-Socio-Economic Conference, the President's Luncheon and of course, the Gaslight Party.

This is it — the place you will want to be October 12-14 for the time of your life! Don't miss it! — J.F.S.

# President's Page

## *We Need Each Other*

In a recent talk before approximately 600 assembled physician members of organized medicine and staff members of state and county societies, Dr. F. J. L. Blasingame, Executive Vice-President of the American Medical Association made the following statement: "Never before has the individual physician been more needed in his medical organization. Never has he needed it more than he does today. It is essential that we have greater participation by more physicians at all organizational levels. . . . The physician must strive to be a complete, effective citizen, concerned not only with the art and science of medicine, but also knowledgeable in its socio-economic environment."



The occasion was the annual Public Relations Conference held in Chicago. Commenting further upon the recent Medicare legislation, Dr. Blasingame stated "in the legislative area, medicine has suffered a defeat but we must recognize it as a Dunkirk and not a Waterloo. Medicare was a battle in a long war which began years ago; it is with us today; and it will extend into the future. This war will continue to make increasing demands on all of us—individually and collectively."

These statements, I believe, summarize why every physician should be a member of his county, state and national medical associations. Here in Indiana, throughout the past year, hardworking commissions made up of from 15 to 20 physicians each, have given considerable thought to many issues including legislation, which will eventually have a direct effect upon each member of the association.

Unquestionably some of the decisions which are made and some of the conclusions which are reached after careful deliberation by these commissions, the Council and the other official bodies of the state medical association are not 100% agreed to by the membership.

The physician who stands on the outside and criticizes what seems to take place on the inside of the organization has this right, of course, but is he being fair with his colleagues who are active, interested, participating members?

During my years as a member of the Indiana State Medical Association and of my own county medical society, I have seen, on occasion, an individual physician walk out on a meeting, resign from a committee, depart from a discussion because the ideas being expressed there or the conclusions being expressed did not seem to coincide with his own.

His attitude was one which reflected the idea that if I can't have my way about this, I'm not going to have any part of it. This I believe is not the way to face up to issues which are going to be brought, increasingly, to bear on organized medicine. Sidestepping these problems, not facing them squarely with purpose, decision and unity will never resolve the issues in which medicine is concerned.

Each member has a right to be heard in the framework of his medical society through the democratic process. I believe that each of us should express ourselves and at the same

time realize that we may be outnumbered and outvoted.

I, personally, feel that every Indiana doctor has an obligation to belong. It is only through his medical organization that he can express himself in a way which ultimately can be heard with a strong voice, without sacrificing individualism, or freedom of thought or action.

Splintering off individually or in small groups, fractioning the strength of organized medicine, can never help us accomplish our objectives; on the contrary, such activity can only hinder. The Indiana State Medical Association needs your membership and activity today — and you need it.

**Remember your state meeting — Oct. 12, 13, 14, 1965 — Come!**

**Medicine is democracy in action.**



# The Woman's Auxiliary

## REPORTS TO ISMA

September is the month of fresh starts and new enthusiasms. Having attended workshops and formulated plans as to possible areas where assistance and guidance are necessary, committees are formed and plans made to consult with medical advisory boards. Health Careers, sponsored by the medical association and supported by the auxiliary, can be an ambitious project. The ISMA has shown its support of the Indiana Health Careers, Inc. by a donation. This is an excellent source for information; the material of "Opportunities Unlimited" is available in book form and describes 51 health careers. Junior high as well as high schools have shown a very real interest in material of this type.



While attending the AMA meeting in New York, it was my privilege to see the new film presentation "A Different Drum." This deals with the AMA's role in basic research through the Institute of Biomedical Research. The photography is outstanding, presented in a pleasing and imaginative manner and gives one a sense of pride in backing up intellectual support with financial assistance. This research program is in addition to the previously sponsored AMA-ERF, actually adding the third prong.

The AMA, as explained by Dr. Smith, gave 1¼ million dollars to deans of medical schools to use at their discretion and secondly, with a fund of close to $38 million, has more than $30 million out on loan to medical students. The Biomedical Research building is in Chicago on North Dearborn Street and will be included in a tour by national and state officers and chairmen in October. The Woman's Auxiliary to the AMA gave $320,121.87 this past year and of this amount $14,344.97 was given by the Woman's Auxiliary to the ISMA. Of our total receipts, $3,585.66 was commission received from the Medallion Card Company for Christmas cards. The Christmas card books are now distributed to each county. You'll be pleased with their quality and enjoy the added satisfaction of knowing you are contributing to your own AMA-ERF.

A joint meeting of the Indiana State Medical Association and the American Medical Association's 25th Congress on Occupational Health will present an opportunity for members to convene in Indianapolis at the Murat Temple October 12th to 14th. Wives accompanying their husbands are requested to register at the Columbia Club from nine to five on Tuesday. Early reservations for Wednesday, October 13th, are urged so the chairman of woman's activities may assure all reservations will be honored. An interesting day is planned by Mrs. Francis L. Land and her committee with the Allen County Medical Auxiliary doing honors as hostesses.

Ruth V. Dunstone

*116th*
*Annual Convention*

# INDIANA STATE MEDICAL ASSOCIATION

*October 11, 12, 13, and 14, 1965*
*All Events on Eastern Standard Time*
*Murat Temple, Indianapolis, Indiana*

*Complete Program and Annual Reports on Following Pages*

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# Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Murat Temple, Indianapolis, Indiana, October 11, 12, 13 and 14, 1965.

The House of Delegates will be constituted as follows: Marion County, 21 delegates; Lake County, eight delegates; Allen County, six delegates; St. Joseph and Vanderburgh county societies, each five delegates; Delaware-Blackford, three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Harrison-Crawford, Jackson-Jennings, Jefferson-Switzerland, LaPorte, Madison, Owen-Monroe, Parke-Vermillion, Tippecanoe, Vigo and Wayne-Union county societies, each two delegates; the other 58 county societies, each one delegate; 13 councilors, and the ex-presidents, namely F. S. Crockett, Herman M. Baker, Karl R. Ruddell, M. A. Austin, Paul D. Crimm, W. Harry Howard, Walter U. Kennedy, Elton R. Clarke, M. C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock and Donald E. Wood, and ex-officio, the president, president-elect, executive secretary and the treasurer of the association, and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president shall cast the deciding vote.

All delegates have been certified by their county medical societies. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 7:00 p.m. Monday, October 11, 1965, in the Ballroom, Columbia Club, and again at 2:00 p.m. Thursday, October 14, 1965, in the Candidates Room, Murat Temple.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Tribute to members of House who have died since the 1964 session.
5. Reading of the minutes of previous meetings.
6. Introduction of guests.
7. Appointment of Reference Committees and assignment of meeting rooms.
8. Unfinished business.
9. Address of president-elect.
10. Report of president of the Woman's Auxiliary.
11. Report of Indiana Chapter Student AMA.
12. Report by president of Blue Shield.
13. Report of executive secretary.
14. Report of treasurer.
15. Report of the chairman of the Council.
16. Reports of councilors.
17. Report of *Journal* editor.
18. AMA Delegates' report.
19. Report of State Board of Medical Registration and Examination.
20. Reports of committees and commissions:

    COMMITTEES:

    (1) Executive
    (2) Grievance
    (3) Student Loan
    (4) Medical-Legal Review
    (5) Building

    COMMISSIONS:

    (1) Convention Arrangements
    (2) Constitution and Bylaws
    (3) Legislation
    (4) Public Information
    (5) Governmental Medical Services
    (6) Public Health
    (7) Voluntary Health Agencies
    (8) Inter-Professional Relations
    (9) Medical Economics and Insurance
    (10) Medical Education and Licensure
    (11) Special Activities
    (12) Aging

21. New Business
    (1) Resolutions.

The election of officers will be the first order of business at the second meeting of the House of Delegates. In addition to the regular officers, the terms of the following officers expire December 31, 1965, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Guy A. Owsley, Hartford City and Jack E. Shields, Brownstown: Alternate delegates to succeed William B. Challman, Mount Vernon and John M. Paris, New Albany.

Delegates from the First, Fourth, Seventh, Tenth and Thirteenth districts are reminded that the terms of their councilors will expire October 14, 1965, and the new councilors should be elected to succeed the following:

First District—P. J. V. Corcoran, Evansville
Fourth District—Robert M. Reid, Columbus
Seventh District—Albert M. Donato, Indianapolis
Tenth District—Lowell H. Steen, Whiting
Thirteenth District—Jene R. Bennett, South Bend

Some of these elections already may have been held, but they should be reported to the House of Delegates at this session for confirmation.

JAMES A. WAGGENER, *Executive Secretary*

# HOUSE OF DELEGATES

## Indiana State Medical Association

## Indiana--October 11, 12, 13 and 14, 1965

| County and Delegates | Alternates |
|---|---|
| **ADAMS** | |
| John E. Doan, Decatur | Robert L. Boze, Berne |
| **ALLEN** | |
| Eugene F. Senseny, Fort Wayne | E. E. Stumpf, Fort Wayne |
| William A. Kleifgen, Fort Wayne | J. S. Farquhar, Fort Wayne |
| W. Lloyd Bridges, Fort Wayne | C. H. Aust, Fort Wayne |
| Richard B. Juergens, Fort Wayne | R. L. Hillery, Fort Wayne |
| Richard G. Fullam, Fort Wayne | W. T. Jurgensen, Fort Wayne |
| Edward D. Miller, Fort Wayne | G. R. Nolan, Fort Wayne |
| **BARTHOLOMEW-BROWN** | |
| Harold W. Richmond, Columbus | Lloyd Gammell, Columbus |
| Robert M. Seibel, Nashville | |
| **BENTON** | |
| **BOONE** | |
| Clarence G. Kern, Lebanon | E. E. Gregg, Thorntown |
| **CARROLL** | |
| T. Neal Petry, Delphi | |
| **CASS** | |
| Earl W. Bailey, Logansport | Donald K. Winter, Logansport |
| **CLARK** | |
| Joel T. Carney, Jeffersonville | Ralph W. Bruner, Jeffersonville |
| **CLAY** | |
| Rahim Farid, Brazil | |
| **CLINTON** | |
| Robert A. Hedgcock, Frankfort | Harry T. Stout, Frankfort |
| **DAVIESS-MARTIN** | |
| A. G. Blazey, Washington | Marshall H. Seat, Washington |
| E. B. Lett, Loogootee | Robert E. Chattin, Loogootee |
| **DEARBORN-OHIO** | |
| Leslie M. Baker, Aurora | Ivan Lindgren, Lawrenceburg |
| Gordon S. Fessler, Rising Sun | Amado Mauricio, Rising Sun |
| **DECATUR** | |
| William Shaffer, Greensburg | Robert Acher, Greensburg |
| **DE KALB** | |
| Bradley Hughes, Waterloo | Clifford Shultz, Butler |

| County and Delegates | Alternates |
|---|---|
| **DELAWARE-BLACKFORD** | |
| Thomas Brown, Muncie | Clyde Botkin, Muncie |
| Glynn Rivers, Muncie | Ross L. Egger, Middletown |
| Dean Jackson, Hartford City | Richard Ingram, Montpelier |
| **DUBOIS** | |
| John Barrow, Dale | Edward Ploetner, Jasper |
| **ELKHART** | |
| **FAYETTE-FRANKLIN** | |
| William F. Kerrigan, Connersville | A. M. Hudson, Connersville |
| H. N. Smith, Brookville | Perry Seal, Brookville |
| **FLOYD** | |
| Donald LaFollette, New Albany | Irvin H. Sonne, New Albany |
| **FOUNTAIN-WARREN** | |
| Lowell Stephens, Covington | Max Hoffman, Covington |
| James W. Crain, Williamsport | Carl Nelson, West Lebanon |
| **FULTON** | |
| Dean Stinson, Rochester | Charles Richardson, Rochester |
| **GIBSON** | |
| R. E. Weitzel, Princeton | Virgil McCarty, Princeton |
| **GRANT** | |
| Robert M. Brown, Marion | Lester L. Renbarger, Marion |
| **GREENE** | |
| Sam Rotman, Jasonville | H. B. Turner, Bloomfield |
| **HAMILTON** | |
| Joseph Lloyd, Noblesville | Adrian Lanning, Noblesville |
| **HANCOCK** | |
| Wayne Endicott, Greenfield | Bob R. Cagle, New Palestine |
| **HARRISON-CRAWFORD** | |
| Samuel W. Martin, Corydon | W. J. Brockman, Corydon |
| Jesse Benz, Marengo | |
| **HENDRICKS** | |
| Malcolm O. Scamahorn, Pittsboro | David Haggard, Plainfield |
| **HENRY** | |
| Kenneth G. Hill, New Castle | William C. Heilman, Jr., New Castle |

| County and Delegates | Alternates |
|---|---|
| **HOWARD** | |
| Warren McClure, Kokomo | |
| **HUNTINGTON** | |
| R. W. Wagner, Huntington | Warren Van Campen, Huntington |
| **JACKSON-JENNINGS** | |
| Harry R. Baxter, Seymour | William D. Scharbrough, Ewing |
| Forrest D. Ellis, North Vernon | Shaffer B. Berkshire, North Vernon |
| **JASPER** | |
| K. R. Ockermann, Rensselaer | |
| **JAY** | |
| James Fitzpatrick, Portland | William Cripe, Portland |
| **JEFFERSON-SWITZERLAND** | |
| Robert O. Zink, Madison | Frank W. Hare, Madison |
| Noel S. Graves, Vevay | Antha A. Hamilton, Vevay |
| **JOHNSON** | |
| Joseph Young, Greenwood | Charles A. Jones, Franklin |
| **KNOX** | |
| Herbert O. Chattin, Vincennes | Walter R. Vaughn, Vincennes |
| **KOSCIUSKO** | |
| William Cron, Warsaw | Thomas Keough, Warsaw |
| **LA GRANGE** | |
| Philip E. Yunker, Howe | John H. Williams, Shipshewana |
| **LAKE** | |
| C. O. Almquist, Gary | Richard J. Purcell, Griffith |
| V. J. Santare, Munster | C. T. Disney, Gary |
| George Thegze, East Chicago | Walfred Nelson, Gary |
| M. B. Gevirtz, Munster | E. A. Campagna, East Chicago |
| Michael Shellhouse, Gary | William J. Fitzpatrick, Hammond |
| P. J. Rosenbloom, Gary | Nicholas Egnatz, Hammond |
| H. W. Eggers, Hammond | Daniel T. Ramker, Hammond |
| Jacob Pruitt, Gary | J. B. Burcham, Gary |
| **LA PORTE** | |
| G. O. Larson, LaPorte | J. C. Richter, LaPorte |
| Thomas D. Armstrong, Michigan City | Amos Arney, Michigan City |
| **LAWRENCE** | |
| J. B. Wohlfeld, Bedford | Donald M. Kerr, Bedford |
| **MADISON** | |
| J. L. Larmore, Anderson | W. A. Laudeman, Elwood |
| A. T. Jones, Anderson | R. D. Williams, Markleville |
| **MARION** | |
| Harry G. Becker, Indianapolis | Warren Coggeshall, Indianapolis |
| John W. Beeler, Indianapolis | Rex M. Joseph, Indianapolis |
| Floyd A. Boyer, Indianapolis | William A. Karsell, Indianapolis |
| | K. R. Manning, Indianapolis |
| Glenn W. Irwin, Jr., Indianapolis | Dennis Nicholas, Indianapolis |
| George T. Lukemeyer, Indianapolis | Robert P. Scott, Indianapolis |
| Loren H. Martin, Indianapolis | Warren S. Tucker, Indianapolis |
| John O. Butler, Indianapolis | E. Jane Brownley, Indianapolis |
| Sprague H. Gardiner, Indianapolis | F. Robert Brueckmann, Indianapolis |
| David Hadley, Indianapolis | Joseph M. Daly, Indianapolis |
| James M. Leffel, Indianapolis | David Lozow, Indianapolis |
| Michael W. Manzie, Indianapolis | Robert W. Mouser, Indianapolis |
| Roland B. Rust, Jr., Indianapolis | Berj Antreasian, Indianapolis |
| Morris E. Thomas, Indianapolis | Austin L. Gardner, Indianapolis |
| Albert M. Donato, Indianapolis | Carroll W. Hasewinkel, Indianapolis |
| Joseph C. Finneran, Indianapolis | Edwin S. McClain, Indianapolis |
| James H. Gosman, Indianapolis | John S. Schechter, Indianapolis |
| Myron H. Nourse, Indianapolis | |
| Dwight W. Schuster, Indianapolis | |
| Donald E. Stephens, Indianapolis | |
| Donald E. Wood, Indianapolis | |
| **MARSHALL** | |
| R. R. Hippensteel, Culver | Donald Reed, Culver |
| **MIAMI** | |
| Lloyd L. Hill, Peru | |
| **MONTGOMERY** | |
| Richard R. Eggers, Crawfordsville | J. M. Kirtley, Crawfordsville |
| **MORGAN** | |
| R. W. Van Bokkelen, Mooresville | David A. Eisenberg, Martinsville |
| **NEWTON** | |
| R. S. Yegerlehner, Kentland | John Parker, Goodland |
| **NOBLE** | |
| Robert E. Bryan, Kendallville | Donald Hooker, Ligonier |
| **ORANGE** | |
| P. T. Hodgin, Orleans | Marion Hagan, French Lick |
| **OWEN-MONROE** | |
| Paul J. Wenzler, Bloomington | James Ross, Bloomington |
| Roger Roof, Spencer | |
| **PARKE-VERMILLION** | |
| W. D. Britton, Montezuma | C. Harstad, Rockville |
| J. M. Kercheval, Clinton | I. L. Gailey, Clinton |
| **PERRY** | |
| Fred Smith, Tell City | |

| County and Delegates | Alternates |
|---|---|
| **PIKE** | |
| Milton Omstead, Petersburg | |
| **PORTER** | |
| Jack E. Dittmer, Valparaiso | Robert M. Stoltz, Valparaiso |
| **POSEY** | |
| L. John Vogel, Mt. Vernon | John R. Crist, Mt. Vernon |
| **PULASKI** | |
| William R. Thompson, Winamac | |
| **PUTNAM** | |
| Richard L. Veach, Bainbridge | James B. Johnson, Greencastle |
| **RANDOLPH** | |
| Lowell W. Painter, Winchester | |
| **RIPLEY** | |
| Bill E. Freeland, Batesville | Lloyd W. Hisrich, Batesville |
| **RUSH** | |
| Frank H. Green, Rushville | |
| **ST. JOSEPH** | |
| N. D. Sisson, South Bend | J. O. Hildebrand, South Bend |
| L. C. Bixler, South Bend | Jacob Rosenwasser, Mishawaka |
| Raymond E. Nelson, South Bend | George D. Colip, South Bend |
| Louis F. Sandock, South Bend | Richard A. Ganser, Mishawaka |
| W. Robert Orr, Mishawaka | William J. Stogdill, South Bend |
| **SCOTT** | |
| James A. Sabens, Scottsburg | |
| **SHELBY** | |
| Wilson L. Dalton, Shelbyville | John A. Davis, Flat Rock |
| **SPENCER** | |
| Michael O. Monar, Rockport | John C. Glackman, Rockport |
| **STARKE** | |
| Guy B. Ingwell, Knox | Clark McClure, Knox |
| **STEUBEN** | |
| Donald G. Mason, Angola | John J. Hartman, Angola |

| County and Delegates | Alternates |
|---|---|
| **SULLIVAN** | |
| Joe E. Dukes, Dugger | J. H. Crowder, Sullivan |
| **TIPPECANOE** | |
| R. B. DuBois, Lafayette | W. R. Van Den Bosch, Lafayette |
| Forrest J. Babb, Stockwell | Julius J. Deur, Lafayette |
| **TIPTON** | |
| A. E. Stouder, Kempton | M. B. Gossard, Tipton |
| **VANDERBURGH** | |
| Ray H. Burnikel, Evansville | William C. Grimm, Evansville |
| J. Guy Hoover, Evansville | Robert Oswald, Evansville |
| Charles M. Sinn, Evansville | James R. Mathews, Evansville |
| George W. Willison, Evansville | Albert Ritz, Evansville |
| John D. Wilson, Evansville | Ralph E. Zwickel, Evansville |
| **VIGO** | |
| Stuart R. Combs, Terre Haute | Fred W. Dierdorf, Terre Haute |
| Thomas J. Conway, Terre Haute | Norman M. Silverman, Terre Haute |
| **WABASH** | |
| Stanley M. Zydlo, Wabash | Robert M. LaSalle, Jr., Wabash |
| **WARRICK** | |
| Wendell C. Stover, Boonville | |
| **WASHINGTON** | |
| Irvin Huckleberry, Salem | T. Kermit Tower, Campbellsburg |
| **WAYNE-UNION** | |
| C. G. Clarkson, Liberty | Frank Lewis, Liberty |
| Glen Ward Lee, Richmond | Tom Shields, Richmond |
| **WELLS** | |
| Truman E. Caylor, Bluffton | John F. Phillips, Bluffton |
| **WHITE** | |
| W. Martin Dickerson, Monticello | Nolan A. Hibner, Monticello |
| **WHITLEY** | |
| Thomas Hamilton, Columbia City | C. Jules Heritier, Columbia City |

### PAST PRESIDENTS

Franklin S. Crockett, West Lafayette
Herman M. Baker, Evansville
Karl R. Ruddell, Indianapolis
M. A. Austin, Evansville
Paul D. Crimm, Evansville
W. Harry Howard, Hammond
W. U. Kennedy, New Castle
Elton R. Clarke, Kokomo
M. C. Topping, Terre Haute
Kenneth L. Olson, South Bend
Earl W. Mericle, Indianapolis
Guy A. Owsley, Hartford City
Maurice E. Glock, Fort Wayne
Donald E. Wood, Indianapolis

### OFFICERS

President—Joe M. Black, Seymour

President-elect—Kenneth O. Neumann, Lafayette

Chairman, Executive Committee—
Ralph V. Everly, Indianapolis

Member, Executive Committee—
G. O. Larson, LaPorte

Treasurer—Ottis N. Olvey, Indianapolis

Chairman of the Council —
E. S. Rifner, Van Buren

Assistant Treasurer—Lester H. Hoyt, Indianapolis

Editor—Frank B. Ramsey, Indianapolis

Executive Secretary—
James A. Waggener, Indianapolis

### COUNCILORS

1st District—P. J. V. Corcoran, Evansville
2nd District—E. T. Edwards, Vincennes
3rd District—Donald M. Kerr, Bedford
4th District—Robert M. Reid, Columbus
5th District—V. Earle Wiseman, Greencastle
6th District—William R. Tindall, Shelbyville
7th District—Albert M. Donato, Indianapolis
8th District—Donald R. Taylor, Muncie
9th District—Peter R. Petrich, Attica
10th District—Lowell H. Steen, Whiting
11th District—E. S. Rifner, Van Buren
12th District—Milton F. Popp, Fort Wayne
13th District—Jene R. Bennett, South Bend

### AMA DELEGATES

Harold C. Ochsner, Indianapolis
E. S. Jones, Hammond
Francis L. Land, Fort Wayne
Guy A. Owsley, Hartford City
Jack E. Shields, Brownstown

## *Fifty-Year Club—1965*

ALLEN
John T. Short, Fort Wayne

CLARK
Henry H. Reeder, Jeffersonville

DUBOIS
Harvey K. Stork, Huntingburg

FAYETTE-FRANKLIN
A. M. Winklepleck, Connersville

SPENCER
Wesley P. Jolly, Richland

TIPPECANOE
Alfred B. Coyner, Lafayette
Frank P. Hunter, Lafayette

WELLS
Emery W. Lehman, Bluffton

MARION
Charles W. Myers, Indianapolis
Roy B. Storms, Indianapolis

# Reference Committees—1965

**SECTIONS AND SECTION WORK:**

A. E. Stouder, Kempton (Tipton), *Chairman*
Sprague H. Gardiner, Indianapolis (Marion)
Forrest J. Babb, Stockwell (Tippecanoe)
William D. Scharbrough, Ewing (Jackson-Jennings)
Charles M. Sinn, Evansville (Vanderburgh)

**RULES AND ORDER OF BUSINESS:**

Lowell W. Painter, Winchester (Randolph), *Chairman*
Earl W. Bailey, Logansport (Cass)
William Shaffer, Greensburg (Decatur)
John O. Butler, Indianapolis (Marion)
Donald R. LaFollette, New Albany (Floyd)

**MEDICAL EDUCATION AND HOSPITALS:**

John W. Beeler, Indianapolis (Marion), *Chairman*
William R. Clark, Fort Wayne (Allen)
Thomas C. Moore, Muncie (Delaware-Blackford)
Glenn W. Irwin, Jr., Indianapolis (Marion)
John D. Wilson, Evansville (Vanderburgh)

**LEGISLATION:**

James H. Gosman, Indianapolis (Marion), *Chairman*
Lee Trachtenberg, Munster (Lake)
Thomas M. Brown, Muncie (Delaware-Blackford)
James M. Kirtley, Crawfordsville (Montgomery)
Clarence G. Kern, Lebanon (Boone)

**PUBLIC RELATIONS:**

Frank H. Green, Rushville (Rush), *Chairman*
Eugene F. Senseny, Fort Wayne (Allen)
George T. Lukemeyer, Indianapolis (Marion)
George W. Willison, Evansville (Vanderburgh)
William F. Kerrigan, Connersville (Fayette-Franklin)

**HYGIENE AND PUBLIC HEALTH:**

Robert M. Seibel, Nashville (Bartholomew-Brown), *Chairman*
Gilbert M. Wilhelmus, Evansville (Vanderburgh)
Michael Shellhouse, Gary (Lake)
Wilson L. Dalton, Shelbyville (Shelby)
Joseph C. Finneran, Indianapolis (Marion)

**AMENDMENTS TO CONSTITUTION AND BYLAWS:**

Gordon S. Fessler, Rising Sun (Dearborn-Ohio), *Chairman*
Paul W. Sparks, Winchester (Randolph)
Thomas D. Armstrong, Michigan City (LaPorte)
Floyd A. Boyer, Indianapolis (Marion)
Joe E. Dukes, Dugger (Sullivan)

**REPORTS OF OFFICERS:**

James W. Crain, Williamsport (Fountain-Warren), *Chairman*
Wendell C. Stover, Boonville (Warrick)
Charles A. Jones, Franklin (Johnson)
Michael W. Manzie, Indianapolis (Marion)
Leslie M. Baker, Aurora (Dearborn-Ohio)

**CREDENTIALS:**

Dean K. Stinson, Rochester (Fulton), *Chairman*
John F. Phillips, Bluffton (Wells)
Robert M. Brown, Marion (Grant)
David Hadley, Indianapolis (Marion)
Bill E. Freeland, Batesville (Ripley)

**INSURANCE:**

Malcolm O. Scamahorn, Pittsboro (Hendricks), *Chairman*
Elmer L. Wallace, New Albany (Floyd)
W. R. Van Den Bosch, Lafayette (Tippecanoe)
M. B. Gevirtz, Munster (Lake)
Harry R. Baxter, Seymour (Jackson-Jennings)

**MISCELLANEOUS BUSINESS:**

Dwight W. Schuster, Indianapolis (Marion), *Chairman*
Lowell J. Hillis, Logansport (Cass)
Glen Ward Lee, Richmond (Wayne-Union)
Thomas J. Conway, Terre Haute (Vigo)
Loren H. Martin, Indianapolis (Marion)

*1964-1965*

# *Officers of the ISMA*



JOE M. BLACK, M.D.

President

Indiana State Medical Association

1964-65



KENNETH O. NEUMANN, M.D.
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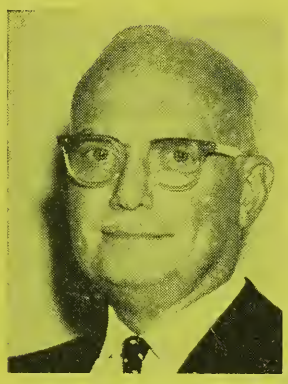
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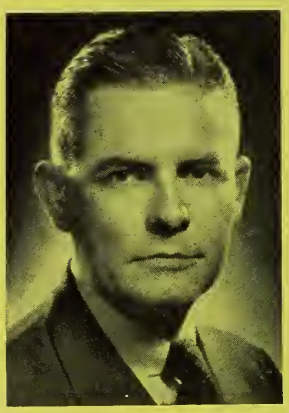


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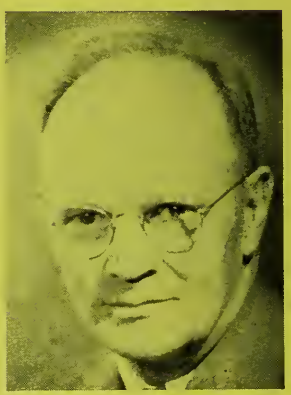
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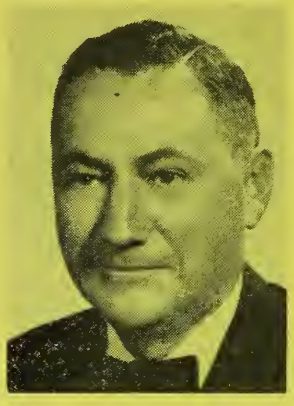
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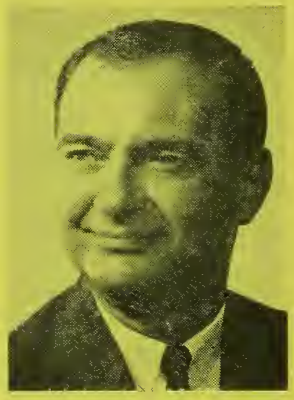


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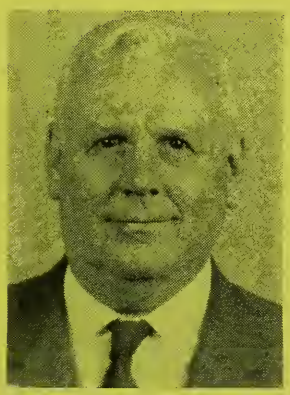
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Warsaw

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# *Schedule of Events*

## 116th Annual Convention

## Indiana State Medical Association

## in conjunction with

## Congress on Occupational Health of

## the American Medical Association

## Murat Temple, Indianapolis, Indiana

## October 11, 12, 13, 14, 1965

(*All Events on Eastern Standard Time*)

*(The scientific program of the 116th annual convention of the Indiana State Medical Association, in conjunction with the Congress on Occupational Health of the American Medical Association, is acceptable for 10½ hours of Category I credit by the American Academy of General Practice.)*

### Saturday, October 9, 1965

9:30 a.m. Council on Occupational Health, Sheraton-Lincoln Hotel. (Closed meeting).

### Sunday, October 10, 1965

9:30 a.m. Council on Occupational Health, Sheraton-Lincoln Hotel. (Closed meeting).

### Monday, October 11, 1965

9:30 a.m. to 5:00 p.m. Council on Occupational Health with State and County Medical Association Committees on Occupational Health, Sheraton-Lincoln Hotel. (Closed meeting).

10:30 a.m. ISMA Executive Committee meeting, Fairbanks Room, fourth floor, Columbia Club.

12:00 noon Council on Occupational Health with State and County Committees luncheon, Sheraton-Lincoln Hotel. (Closed meeting).

2:00 p.m. ISMA Council meeting, Parlors B and C, fourth floor, Columbia Club.

7:00 p.m. ISMA House of Delegates meeting, Ballroom, Columbia Club. (Not a dinner meeting).

### Tuesday Morning, October 12, 1965

8:00 a.m. ISMA Council breakfast meeting, Harrison Room, Columbia Club.

8:30 a.m. Registration starts, Theatre lobby, Murat Temple.

8:30 a.m. Opening of technical and scientific exhibits, lounge room, Murat Temple.

9:00 a.m. ISMA Reference Committee meetings, basement dining room, Murat Temple.

10:00 a.m. to 12 noon Continuous MOVIES, Murat Temple.

*Group A*: Basement Foyer, Murat Temple.

1. Complete Vaginal Repair: A Simplified Approach (Eaton).
2. Vaginal Hysterectomy, A Simplified Technique (Davis & Geck).
3. Complete Cesarean Hysterectomy (Davis & Geck).
4. Radical Hysterectomy following Central Irradiation for Carcinoma of the Cervix (Davis & Geck).

*Group B*: Basement dining room, Murat Temple.

1. Diagnosis and Treatment of Renal Vascular Hypertension (Eaton).
2. The Urological Examination (Eaton).

3. Anorectal and Sigmoidoscopic Examination with Differential Diagnosis (Ayerst).
4. Chronic Bronchitis and Emphysema (Eli Lilly and Company).
5. Fluid Management in Intestinal Obstruction (Davis & Geck).

*Group C*: Candidates Room, Murat Temple.

1. Gastrectomy: The Place of Conservative Resection in the Management of Duodenal Ulcer (Davis & Geck).
2. Cholecystectomy for Acute Cholecystitis and Common Duct Exploration (Davis & Geck).
3. Ligation and Stripping of Varicose Veins (Davis & Geck).
4. Surgical Treatment of Diverticulitis (Davis & Geck).

*Group D*: Egyptian Room, Murat Temple.

1. Initial Care of Burns (Davis & Geck).
2. Basic Principles of Management of the Local Burn Wound (Davis & Geck).
3. Microdermografting Procedure (Eaton).
4. The Treatment of Deafness by Prosthesis (Ayerst).
5. Deafness and the Temporal Bone Bank (Deafness Research Foundation).

## Tuesday Noon, October 12, 1965

12:00 noon — Luncheon meeting of past president of the Indiana State Medical Association, Ladies Parlors (small room), Athenaeum.

12:00 noon — ISMA Editorial Board luncheon meeting, Directors' Room, Athenaeum.

12 noon to 2:00 p.m. — **ISMA SECTION MEETINGS**

12:00 noon to 2:00 p.m. — SECTION ON SURGERY and Indiana chapter of the American College of Surgeons joint luncheon meeting, Fountain Room, Monte's at Riley Center.

Symposium on *"Hyperbaric Oxygen,"*

Election of Section officers for 1966.

12:00 noon to 2:00 p.m. — SECTION ON INTERNAL MEDICINE luncheon meeting, Veterans Room, Athenaeum.

*"Prognostic Significance of the ECG with Particular Reference to the Exercise Test,"*
RICHARD S. GUBNER, M.D., New York, New York

*"Non-Specificity of the T-Wave,"*
CHARLES FISCH, M.D., Indianapolis

Election of Section officers for 1966.



**CHARLES FISCH, M.D.**
**Indianapolis**
Professor of Medicine and Chief, Division of Cardiology, Indiana University School of Medicine; Director, Krannert Heart Research Institute; M.D. degree from the Indiana University School of Medicine, 1944.

## Tuesday Afternoon, October 12, 1965

## SECTION MEETINGS

12:00 noon to 2:00 p.m. SECTION ON GENERAL PRACTICE luncheon meeting, Basement dining room, Murat Temple

Panel discussion: *"Recent Advances in Treatment of Infectious Diseases,"*

RICHARD S. GRIFFITH, M.D., Indianapolis

JACK C. MOORE, M.D., Muncie

JOE E. GAHIMER, M.D., Anderson

Election of Section officers for 1966.

12:00 noon Luncheon and election of Section officers for 1966, SECTION ON OBSTETRICS AND GYNECOLOGY, Ladies Parlors (large room), Athenaeum.

ELFRED H. LAMPE, M.D., chairman, Fort Wayne, presiding

1:00 to 1:30 p.m. *"Maternal Mortality in Indiana,"* CARL P. HUBER, M.D., Indianapolis

1:30 to 2:00 p.m. *"Management of Dysfunctional Menstrual Disorders,"* CHARLES ECHT, M.D., Indianapolis

1:00 p.m. SECTION ON PUBLIC HEALTH AND PREVENTIVE MEDICINE, Candidates Room, Murat Temple.

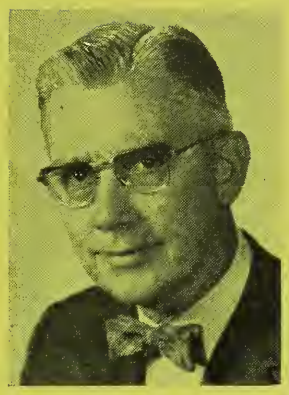
Election of Section officers for 1966

12:00 to 2:00 p.m. Joint luncheon meeting of SECTION ON RADIOLOGY and Indiana Roentgen Society, Blue Room, Athenaeum.

Speaker:
ROSCOE E. MILLER, M.D., Indianapolis

Election of Section officers for 1966

## SPEAKERS



**RICHARD S. GRIFFITH, M.D.**
**Indianapolis**
Associate Professor of Medicine, Indiana University School of Medicine; Head of the Department of Clinical Microbiology, Lilly Laboratory for Clinical Research, Marion County General Hospital; M.D. degree from I.U. School of Medicine, 1944.



**CARL P. HUBER, M.D.**
**Indianapolis**
Professor and Chairman, Department of Obstetrics and Gynecology, I. U. School of Medicine; President of the American Board of Obstetrics and Gynecology; Chairman of the Residency Review Committee for Obstetrics and Gynecology; M.D. degree from the University of Michigan School of Medicine, 1928.



**CHARLES R. ECHT, M.D.**
**Indianapolis**
Instructor, Indiana University Department of Obstetrics and Gynecology, Indiana University School of Medicine; Specialist in obstetrics and gynecology; M.D. degree from Indiana University School of Medicine, 1957.



**ROSCOE E. MILLER, M.D.**
**Indianapolis**
Associate Professor, Indiana University School of Medicine; Consultant, Station Hospital, Fort Benjamin Harrison, Indiana; Specialist in radiology; M.D. degree from the Indiana University School of Medicine, 1951.

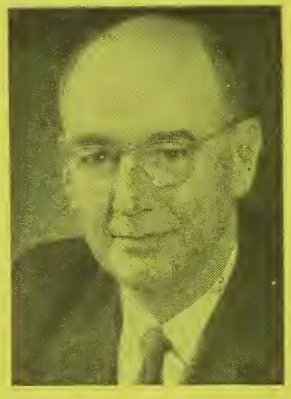
## SPEAKERS



**GEOFFREY SEGAR, J.D.**
**Indianapolis**
Specialist in insurance and workmen's compensation litigation; member of the Indianapolis, Indiana and American Bar Associations and the Indiana State Chamber of Commerce Workmen's Compensation Committee; J. D. from Indiana University, 1952.



**ELI S. JONES, M.D.**
**Hammond, Ind.**
Chief of Surgery, St. Margaret Hospital, Hammond; Senior Member, Jones Clinic, Hammond; Specialist in surgery and occupational medicine; Chairman, AMA Council on Occupational Health; M.D. degree from the Indiana University School of Medicine, 1916.



**JAMES Z. APPEL, M.D.**
**Lancaster, Pa.**
President of the American Medical Association; President of the staff of Lancaster General Hospital; Director of Health Services, Franklin and Marshall College, Lancaster; U.S. delegate to the World Health Organization; M.D. degree from University of Pennsylvania, 1932.



**A. H. HIRSCHFELD, M.D.**
**Detroit, Mich.**
Assistant Clinical Professor, Psychiatry and Occupational Medicine, Wayne State University School of Medicine; Chief Consultant in psychiatry, Circuit Court, Wayne County, Mich.; M.D. degree from University of Michigan, 1939.

## Tuesday Afternoon, October 12, 1965

### SECTION MEETINGS

12:00 noon — SECTION ON PATHOLOGY and Indiana Association of Pathologists joint luncheon meeting, Fraternity Room, Athenaeum.

1:00 p.m. — *"The Pathologists' Role in Workmen's Compensation,"*
GEOFFREY SEGAR, J.D., Indianapolis

Election of Section officers for 1966

## Tuesday Afternoon, October 12, 1965

### JOINT SCIENTIFIC MEETING INDIANA STATE MEDICAL ASSOCIATION and AMA CONGRESS ON OCCUPATIONAL HEALTH

(Egyptian Room, Murat Temple)

E. S. Jones, M.D., Hammond, Indiana, Chairman, AMA Council on Occupational Health, presiding

2:00 p.m. — *Greetings*: JOE M. BLACK, M.D., Seymour, President, Indiana State Medical Association

*Address*: JAMES Z. APPEL, M.D., Lancaster, Pennsylvania, President, American Medical Association

2:20 p.m. — *"Disability without Disease or Accident,"*
A. H. HIRSCHFELD, M.D., Detroit, Michigan

2:50 to 3:20 p.m. — Time allowed to view technical and scientific exhibits, lounge room, Murat Temple.

## Tuesday Afternoon, October 12, 1965

### SCIENTIFIC MEETING

3:20 p.m. CLINICAL-PATHOLOGICAL CONFERENCE

*Moderator*:

JAN H. TILLISCH, M.D., Rochester, Minnesota

*Participants*:

R. LOMAX WELLS, M.D., Washington, D.C.

LEMUEL C. McGEE, M.D., Wilmington, Delaware

EMMETT B. LAMB, M.D., Indidianapolis, Indiana

4:00 to 5:00 p.m. Time allowed to view technical and scientific exhibits, lounge room, Murat Temple.

## Tuesday Evening, October 12, 1965

6:00 p.m. Reception and annual dinner meeting for women physicians of Indiana, Parlors D and E, fifth floor, Indianapolis Athletic Club.

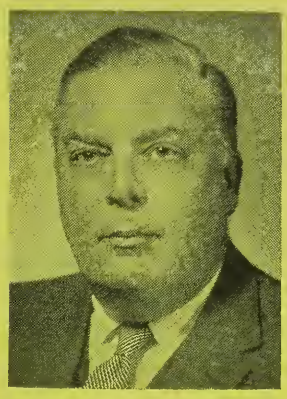
6:00 p.m. Indiana Chapter of the American College of Chest Physicians Annual Dinner and Business meeting, third floor, Columbia Club. (Open to all physicians.)

*"Surgical Care of Coronary Artery Disease,"*

DONALD B. EFFLER, M.D., Cleveland, Ohio.

8:00 p.m. Fireside Conferences, sponsored by Indiana Chapter of the American College of Chest Physicians, Ballroom, Columbia Club. (Open to all physicians.)

## SPEAKERS



**JAN H. TILLISCH, M.D.**
**Rochester, Minn.**
Consultant in internal medicine, Mayo Clinic; Specialist in internal medicine and aviation medicine; Medical Director, Northwest Airlines; M.D. degree from the University of Minnesota Medical School, 1933.



**R. LOMAX WELLS, M.D.**
**Washington, D. C.**
Lecturer in industrial medicine, Georgetown University School of Medicine; General Medical Director, The Chesapeake and Potomac Telephone Companies; M.D. degree from the University of Virginia School of Medicine, 1930.



**LEMUEL C. McGEE, M.D.**
**Wilmington, Del.**
Attending Chief, Department of Medicine, Delaware Hospital, Wilmington; Medical Director, Hercules Powder Co., Wilmington; Visiting Professor of Industrial Medicine, University of Pennsylvania School of Medicine; M.D. degree from Rush Medical College, University of Chicago, 1929.



**EMMETT B. LAMB, M.D.**
**Indianapolis**
Physician in Charge of Indianapolis Works, International Harvester Company, Indianapolis; Medical Director of P. R. Mallory Co., Indianapolis; M.D. degree from Indiana University School of Medicine, 1931.

## Fireside Conferences
## on
## CARDIO-RESPIRATORY DISEASES

### Tuesday, October 12, 1965, 8:00 p.m.

### *Ballroom, Columbia Club*

This is an annual feature of the convention sponsored by the Indiana State Medical Association and the Indiana Chapter of the American College of Chest Physicians for all physicians. The conferences are informal and unrehearsed, providing an opportunity for free discussion of many subjects of interest to general practitioners and specialists alike. A panel of experts will be seated at each of ten tables, and physicians are encouraged to ask questions, express their own ideas and comment on the various problems under discussion. They may move from one table to another if and when they wish. (Complimentary refreshments will be served during the evening.)

### Honored Guest Participants

LEON J. WARSHAW, M.D., Medical Director, Paramount Pictures Corp. and United Artists Corp., New York, N.Y.; Specialist in internal medicine, cardiology and occupational medicine; Research Director of the Industrial Health Research Foundation, Inc.

LEMUEL C. McGEE, M.D., Medical Director, Hercules Powder Company, Wilmington, Del.; Attending Chief, Department of Medicine, Delaware Hospital; Visiting Professor of Industrial Medicine, School of Medicine, University of Pennsylvania.

DONALD B. EFFLER, M.D., Department of Cardiovascular and Thoracic Surgery, Cleveland Clinic, Cleveland, Ohio.

O. A. SANDER, M.D., Clinical Professor of Occupational and Environmental Medicine, Marquette University School of Medicine, Milwaukee, Wis.

1. *Pulmonary Embolism and Infarction*
   - Moderator: KENNETH R. WOOLLING, M.D., Indianapolis
   - Panelists: JOHN W. BEELER, M.D., Indianapolis
   - THOMAS E. LUNSFORD, M.D., Indianapolis
   - FRANCIS W. HARE, JR., M.D., Madison
2. *The Kidney, Renal Arteries and Hypertension*
   - Moderator: HAROLD F. BURDETTE, M.D., Indianapolis
   - Panelists: JAMES M. JAY, M.D., Indianapolis
   - GEORGE T. LUKEMEYER, M.D., Indianapolis
   - SAVERIO CAPUTI, M.D., Indianapolis
3. *The Management of Coronary Insufficiency*
   - Moderator: MORRIS E. THOMAS, M.D., Indianapolis
   - Panelists: WARREN E. COGGESHALL, M.D., Indianapolis
   - CHARLES F. SEAMAN, M.D., Indianapolis
   - RICHARD H. JOWITT, M.D., Indianapolis
4. *Disability and Rehabilitation Aspects of the Cardiac Patient*
   - Moderator: RICHARD M. NAY, M.D., Indianapolis
   - Panelists: ROBERT B. CHEVALIER, M.D., Indianapolis
   - Consultants: LEON WARSHAW, M.D., New York
   - LEMUEL C. McGEE, M.D., Wilmington, Del.
5. *Advances in Heart Surgery*
   - Moderator: A. D. DENNISON, JR., M.D., Indianapolis
   - Consultants: DONALD B. EFFLER, M.D., Cleveland, Ohio
   - HARRIS B SHUMACKER, Jr., M.D., Indianapolis
   - HARVEY FEIGENBAUM, M.D., Indianapolis
6. *Disability and Rehabilitation Aspects of Pulmonary Disease*
   - Moderator: ARVINE G. POPPLEWELL, M.D., Indianapolis
   - Consultants: O. A. SANDER, M.D., Milwaukee, Wis.
   - CHARLES BECK, M.D., Indianapolis
7. *Pediatric Chest Problems*
   - Moderator: JAMES K. HILL, M.D., Indianapolis
   - Panelists: DONALD W. BRODIE, M.D., Indianapolis
   - WENDELL E. BROWN, M.D., Indianapolis
   - CHARLES Y. KNOWLES, M.D., Indianapolis
8. *The Treatment of Suppurative Lung Disease*
   - Moderator: JOHN V. THOMPSON, M.D., Indianapolis
   - Panelists: WARREN S. TUCKER, M.D., Indianapolis
   - JOSEPH C. ROSS, M.D., Indianapolis
   - ALFONS LANDWEHR, M.D., Indianapolis
9. *Complicating Cardiopulmonary Problems in Diabetes*
   - Moderator: JOHN D. MILLER, M.D., Indianapolis
   - Panelists: EDWARD F. STEINMETZ, M.D., Indianapolis
   - WILLIAM R. KIRTLEY, M.D., Indianapolis
   - IRVIN W. WILKINS, M.D., Indianapolis
10. *Management of Asthma, Bronchitis and Emphysma*
    - Moderator: DONALD MacLEOD, M.D., West Lafayette
    - Panelists: IRVIN CAPLIN, M.D., Indianapolis
    - JOSEPH D. HOWELL, M.D., Indianapolis
    - RAMON S. DUNKIN, M.D., Indianapolis

## Wednesday Morning, October 13, 1965

8:00 a.m. ISMA Council breakfast meeting, Harrison Room, Columbia Club.

8:30 a.m. Registration continues, Theatre lobby, Murat Temple.

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.

8:30 to 10:30 a.m. Tour of Indiana University Medical Center (Buses will leave Murat Temple on the quarter hour — courtesy of Eli Lilly & Company).

8:30 to 10:30 a.m. Continuous MOVIES, Murat Temple. Repeat of Tuesday, October 12, program.

10:00 to 10:30 a.m. Time allowed to view technical and scientific exhibits, lounge room, Murat Temple.

## SPEAKERS



**LEON J. WARSHAW, M.D.**
**New York, N. Y.**
Medical Director, Paramount Pictures Corp. and United Artists Corp.; Specialist in internal medicine, cardiology and occupational medicine; Research Director of the Industrial Health Research Foundation, Inc.; M.D. degree from Columbia University College of Physicians and Surgeons, 1942.

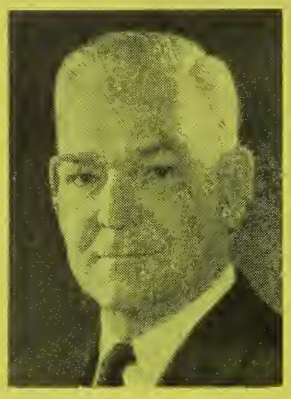


**O. A. SANDER, M.D.**
**Milwaukee, Wis.**
Clinical Professor of Occupational and Environmental Medicine, Marquette University School of Medicine; M.D. degree from the University of Pennsylvania School of Medicine, 1927.

### *THE EXHIBITS*

We urge you to visit with the exhibitors — they are here to help you —and to bring you the latest information. They contribute to financing your convention.

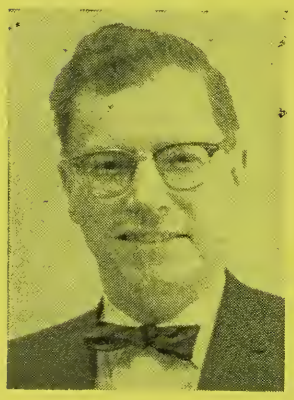
## SPEAKERS



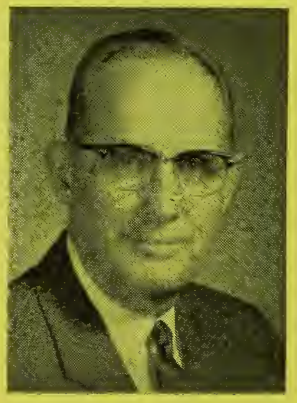
**GEORGE F. WILKINS, M.D.**
**Boston, Mass.**
Associate Clinical Professor of Occupational Medicine, Harvard School of Public Health; Medical Director, New England Telephone & Telegraph Company; Specialist in occupational medicine; M.D. degree from Harvard Medical School, 1932.



**FRANCIS L. LAND, M.D.**
**Fort Wayne, Ind.**
Industrial physician, several small industries; Member of the AMA Council on Medical Education; Vice-president of the American Academy of General Practice; M.D. degree from Indiana University School of Medicine, 1950.



**MARK W. GRAY, LL.B.**
**Indianapolis**
Chairman of the State Chamber of Commerce Workmen's Compensation Committee; Member of the Indiana Wage Adjustment Board; LL.B. from Indiana University, 1940.



**ASA BARNES, M.D.**
**Beckley, W. Va.**
Assistant Clinical Professor of Industrial Medicine, Department of Preventive Medicine and Industrial Health, College of Medicine, University of Cincinnati; Area Medical Administrator, United Mine Workers of America Welfare and Retirement Fund, Beckley, W. Va.; M.D. degree from the University of Missouri, 1929.

## Wednesday Morning, October 13, 1965

# JOINT SCIENTIFIC MEETING INDIANA STATE MEDICAL ASSOCIATION and AMA CONGRESS ON OCCUPATIONAL HEALTH

(Egyptian Room, Murat Temple)

Joe M. Black, M.D., Seymour, president, Indiana State Medical Association, presiding

10:30 a.m. *Symposium*: *"Role of the Family Physician in Workmen's Compensation,"*

*Moderator*:
GEORGE F. WILKINS, M.D., Boston, Massachusetts

*"Legal Aspects,"*
GEOFFREY SEGAR, J.D., Indianapolis, Indiana

*"Reporting Procedures,"*
EMMETT B. LAMB, M.D., Indianapolis, Indiana

*"Disability Evaluation,"*
FRANCIS L. LAND, M.D., Fort Wayne, Indiana

*"Rehabilitation Aspects,"*
MARK W. GRAY, LL.B., Indianapolis, Indiana

*"Labor's Views,"*
ASA BARNES, M.D., Beckley, W. Virginia

## Wednesday Noon, October 13, 1965

12:00 noon — Joint luncheon, INDIANA STATE MEDICAL ASSOCIATION and AMA COUNCIL ON OCCUPATIONAL HEALTH, Kellersaal, Athenaeum

Presentation of Physician's Award of President's Committee on Employment of the Handicapped.

Presiding: George F. Wilkins, M.D., Boston

*Presentation*: Mr. Harold Russell, Washington, D. C.

*Address*: MR. HENRY VISCARDI, Jr., LL.D., Albertson, New York

12:00 noon — SECTION ON NERVOUS AND MENTAL DISEASES luncheon and business meeting, Veterans Room, Athenaeum.

*Speaker*: LEONARD E. HIMLER, M.D., Ann Arbor, Michigan

Election of Section officers for 1966.

12:00 noon — Phi Rho Sigma luncheon, East Room, Athenaeum.

12:00 noon — Phi Beta Pi luncheon, Blue Room, Athenaeum.

12:00 noon — Phi Chi luncheon, Ladies Parlors (large room), Athenaeum.

12:00 noon — Nu Sigma Nu luncheon, Directors' Room, Athenaeum.

## Wednesday Afternoon, October 13, 1965

1:00 p.m. — Flying Physicians Association, Indiana Chapter, meeting, Basement Foyer, Murat Temple. (Not a luncheon meeting.)

1:00 p.m. — Indiana Bone and Joint Club meeting, Fraternity Room, Athenaeum. (Not a luncheon meeting.)

1:00 p.m. — Meeting of small county delegates, Candidates Room, Murat Temple.

## SPEAKERS



**HENRY VISCARDI, Jr., LL.D.**
**Albertson, New York**
Assistant Professor of Clinical Physical Medicine and Rehabilitation, New York University College of Medicine; President, Abilities Inc. & Human Resources; Member of the President's Panel on Mental Retardation and the President's Committee on Employment of the Handicapped.



**LEONARD E. HIMLER, M.D.**
**Ann Arbor, Mich.**
Chairman of Staff, Medical Director, Mercywood Sanitarium, Ann Arbor; Specialist in psychiatry and occupational medicine; Member and former chairman, AMA Joint Committee on Mental Health in Industry; M.D. degree from the University of Michigan, 1931.

The Biggest Fun Event Ever—

Don't miss the

### GASLIGHT PARTY

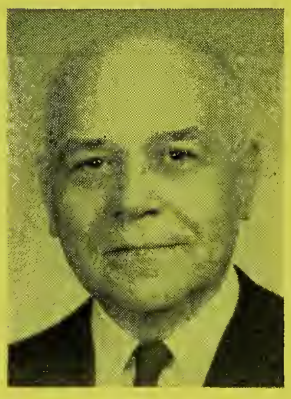
Wednesday, Oct. 13th

9 p.m., Athenaeum

Both the Chicago and New York Gaslight Clubs will move to Indianapolis for the evening —Dixieland Music—Gaslight Girls—Your favorite tunes by old time piano players—Plan now to attend—Bring your friends.



**RICHARD A. SUTTER, M.D.**
**St. Louis, Mo.**
Lecturer in Industrial Medicine and Rehabilitation in Preventive Medicine, Washington University School of Medicine; Director, Sutter Clinic, St. Louis; Specialist in occupational medicine; M.D. degree from Washington University School of Medicine, 1935.



**GRADIE R. ROWNTREE, M.D.**
**Louisville, Ky.**
Professor of Occupational Medicine, University of Louisville School of Medicine; Medical Director, Fawcett-Haynes Printing Corp., Louisville; M.D. degree from the University of Arkansas School of Medicine, 1932.

## JOINT SCIENTIFIC MEETING INDIANA STATE MEDICAL ASSOCIATION and AMA CONGRESS ON OCCUPATIONAL HEALTH

(Egyptian Room, Murat Temple)

Joe M. Black, M.D., Seymour, President, Indiana State Medical Association, presiding

2:00 p.m. *"Recognition of the Disturbed Employee,"*
LEONARD E. HIMLER, M.D., Ann Arbor, Michigan

2:30 to 3:00 p.m. Time allowed to view technical and scientific exhibits, lounge room, Murat Temple.

3:00 p.m. *Symposium: "Role of the Family Physician in Employee Health Problems,"*

*Moderator:*
RICHARD A. SUTTER, M.D., St. Louis, Missouri

*"Immunizing Employees,"*
R. LOMAX WELLS, M.D., Washington, D. C.

*"Keeping Emphysema Patients on the Job,"*
O. A. SANDER, M.D., Milwaukee, Wisconsin

*"Putting the Cardiac Back to Work,"*
LEON J. WARSHAW, M.D., New York, New York

*"Employee Health in General,"*
GRADIE ROWNTREE, M.D., Louisville, Kentucky

WHAT DOES TOMORROW HOLD?

**MEDICAL-SOCIO-ECONOMIC CONFERENCE**

This promises to be one of the outstanding meetings of the convention. Be sure to make plans NOW to attend.

Thursday, October 14

Theater, Murat Temple

## Wednesday Evening, October 13, 1965

9:00 p.m. Gaslight Party, Athenaeum.

## Thursday Morning, October 14, 1965

8:00 a.m. ISMA Council breakfast meeting, Harrison Room, Columbia Club.

8:30 a.m. Registration continues, Theatre lobby, Murat Temple.

8:30 a.m. Technical and scientific exhibits, lounge room, Murat Temple.

9:00 to 10:00 a.m. Time allowed to view technical and scientific exhibits.

## JOINT SCIENTIFIC MEETING INDIANA STATE MEDICAL ASSOCIATION and AMA CONGRESS ON OCCUPATIONAL HEALTH

(Theatre, Murat Temple)

Joe M. Black, M.D., Seymour, president, Indiana State Medical Association, presiding

10:00 a.m. *"The Physician and Automobile Safety,"* ABRAHAM J. MIRKIN, M.D., Cumberland, Maryland

10:30 a.m. to 12 noon MEDICAL-SOCIO-ECONOMIC CONFERENCE

*Moderator*: LEMUEL C. McGEE, M.D., Wilmington, Delaware

*"Industrial Commission View:"* MR. RICHARD W. GUTHRIE, LL.B., Indianapolis, Indiana

*"What Management Expects:"* MR. E. H. BELLOWS, New York, New York

MR. ROBERT PARKER, New York, New York

*"Insurance Company View:"* MR. CARL ASHMAN, Fort Wayne, Indiana

11:00 a.m. Reception for members of ISMA Fifty-Year Club, Foyer, Candidates Room, Murat Temple.

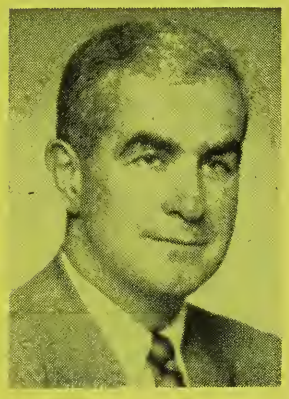
## SPEAKERS



**ABRAHAM J. MIRKIN, M.D.**
**Cumberland, Md.**
Senior attending surgeon, Memorial Hospital and Sacred Heart Hospital, Cumberland; Past-president of the American Association for Automotive Medicine; Chairman, AMA Committee on Medical Aspects of Automotive Safety; M.D. degree from the New York University College of Medicine, 1935.



**EVERETT H. BELLOWS**
**New York, N. Y.**
Vice-president—Corporate Services, Olin Mathieson Chemical Corp., New York; Former consultant to the U. S. Department of State.



**ROBERT PARKER**
**New York, N. Y.**
Assistant to the President, American Brake Shoe Co., New York; Formerly Director of Safety for the company.



**CARL R. ASHMAN**
**Fort Wayne, Ind.**
Second Vice-President and actuary, The Lincoln National Life Insurance Co.; Member of the Indiana Commission on the Aging and Aged; Fellow of the Society of Actuaries.

## SPEAKERS



**DONALD J. BIRMINGHAM, M.D.**
**Detroit, Mich.**
Professor, Department of Dermatology and Syphilology, Wayne State University School of Medicine, Detroit; M.D. degree from St. Louis University School of Medicine, 1940.



**CHARLES W. WYMAN**
**Chicago, Ill.**
Senior Staff Engineer, Industrial Hygiene and Safety Engineering, Western Electric Company; Member of the American Industrial Hygiene Assn.; American Society of Safety Engineers; Western Society of Engineers.



**LEONARD ARLING, M.D.**
**Minneapolis, Minn.**
Founder of the Northwest Industrial Clinic, Minneapolis; Specialist in occupational medicine; branch physician to the Ford Motor Company assembly plant, Saint Paul; M.D. degree from University of Minnesota Medical School, 1936.

## Thursday Noon, October 14, 1965

12:00 noon ISMA President's luncheon, Egyptian Room, Murat Temple

## Thursday Afternoon, October 14, 1965

2:00 p.m. Final meeting of House of Delegates, Candidates Room, Murat Temple

Election of officers.

Meeting of Council and Executive Committee immediately following adjournment of House of Delegates.

## JOINT SCIENTIFIC MEETING INDIANA STATE MEDICAL ASSOCIATION and AMA CONGRESS ON OCCUPATIONAL HEALTH

(Theatre, Murat Temple)

E. S. Jones, M.D., Hammond, presiding

2:30 p.m. *"Preventable Occupational Dermatoses,"*
DONALD J. BIRMINGHAM, M.D., Detroit, Michigan

3:00 to 3:30 p.m. Time allowed to view technical and scientific exhibits.

3:30 p.m. *"Personal Protective Equipment for Employees,"*
MR. CHARLES W. WYMAN, Chicago, Illinois

4:00 p.m. *"Industrial Clinics and Occupational Health,"*
LEONARD ARLING, M.D., Minneapolis, Minnesota

6:30 p.m. 25th CONGRESS ON OCCUPATIONAL HEALTH ANNIVERSARY DINNER, Columbia Club.

(Invitational Only).

James H. Sterner, M.D., Rochester, New York, Master of Ceremonies

Special ceremony honoring former members of the AMA Council on Occupational Health

*Film-talk*, THOMAS A. HANNA, M.D., Indianapolis



**JAMES H. STERNER, M.D.**
**Rochester, N. Y.**
Clinical Associate Professor of Medicine (Occupational Medicine) and Clinical Associate Professor of Preventive Medicine and Community Health, University of Rochester School of Medicine and Dentistry; Corporate Medical Director, Eastman Kodak Company; M.D. degree from the Harvard Medical School, 1932.



**THOMAS A. HANNA, M.D.**
**Indianapolis**
Medical Director, Indianapolis Motor Speedway; M.D. degree from the Indiana University School of Medicine, 1933.

BE SURE TO SEE—

"A History of Medicine in Pictures," presented through the courtesy of Parke, Davis & Company will be an added attraction at this year's convention.

The exhibit, which will be placed in the Egyptian Room, consists of 45 original oil paintings, accompanied by brief captions. The large, colorful paintings are authentic as to detail, setting and historical significance and record the highlights of the health profession from the dawn of history to the present day.

Painted over a period of 10 years, these illustrations resulted from painstaking research conducted in many countries.

# Auxiliary Program

Mrs. Francis L. Land, Fort Wayne, chairman

### Tuesday, October 12, 1965

9:00 to 5:00 p.m. Registration, Murat Temple or Mezzanine, Columbia Club.

### Wednesday, October 13, 1965

9:00 to 11:00 a.m. Registration, Murat Temple or Mezzanine, Columbia Club.
Coffee and rolls.

9:30 a.m. General Assembly meeting, Parlor A, Columbia Club.
All members invited.

### Wednesday, October 13, 1965

11:30 a.m. to 12:30 p.m. Social hour.

12:30 p.m. Luncheon, Ballroom, Columbia Club.

9:00 p.m. Gaslight Party, in conjunction with the Indiana State Medical Association.

### Thursday, October 14, 1965

12:00 noon ISMA President's luncheon, Egyptian Room, Murat Temple.

# Convention Arrangements Committees

GENERAL CONVENTION ARRANGEMENTS: John Mader, Richmond, chairman; Francis E. Stout, Muncie, vice-chairman; Richard B. Hovda, Evansville; Irvin Sonne, New Albany; Merritt O. Alcorn, Madison; John E. Freed, Jr., Terre Haute; William M. Kendrick, Mooresville; Boyd A. Burkhardt, Tipton; Durward W. Paris, Kokomo; Kenneth Kohlstaedt, Indianapolis; Charles Fisch, Indianapolis.

ENTERTAINMENT: William M. Kendrick, Mooresville.

SCIENTIFIC EXHIBITS: Richard B. Hovda, Evansville.

MOVIES: Francis E. Stout, Muncie.

WOMEN PHYSICIANS: Martha C. Souter, Indianapolis.

WOMEN'S ENTERTAINMENT: Mrs. Francis L. Land, Fort Wayne.

FIFTY-YEAR CLUB RECEPTION: Will C. Moore, Muncie.

ART AND HOBBY SHOW: Charles P. Schneider, Evansville.

# Reports of Officers

## Executive Secretary

The report of your Executive Secretary will be brief inasmuch as a full account of the activities of the association is carried in the reports of the Executive Committee, the Council and the various committees and commissions.

The legislative activities, both at the state and national levels, have consumed much of the time of the staff and it does not appear that future months hold much reduction of this activity in view of the various legislative measures which have been adopted by the current session of the Congress.

As approved by the House of Delegates in 1964, the association has installed its own addressing system and now maintains its own mailing list. Mailing of our own publications was begun on April 1, 1965. We are now able to break down our addressing system by specialty categories and this will no doubt be of great use in the future in many of the activities of the association.

The printing department was installed in March and has been put to good use on many different occasions.

You will note from the report of the Building Committee that the indebtedness on the building has been reduced to $36,000 and it is hopeful that the balance can be eliminated within the next two years.

The Medicare Department processed almost one-half million dollars worth of claims during the past year and with the call-up evident for the Viet Nam conflict, this volume will no doubt show a marked increase during the coming months.

Membership in the association has held fairly steady with 19 of the 80 counties showing a slight increase in membership over a year ago.

The association and its members are faced with many vital decisions in the coming months as the Social Security plan for hospital and medical care is implemented. This program becomes effective July 1, 1966. No one knows exactly what the future holds for the practice of medicine and the operation of the country's health facilities. While the history of medicine has had many crises before it in the past years, I doubt that any measure which has been enacted by the Congress holds more danger for a complete revamping of our health system than the passage of H.R.-6675. It will take many hours of serious consideration by your officers and the various committees and commissions in the coming few months to attempt to come up with the right answers and to safeguard the practice of medicine against the inroads of further dictation and regimentation by the federal government.

The cost of the practice of medicine will increase due to the compulsory inclusion of physicians under the Social Security system. Physicians will pay the tax retroactive to January 1, 1965 at a rate of 5.4% on the first $4,800.00 of their income. This indicates that each member will have an additional tax of $259.20 to be paid for the year 1965. Beginning in 1966, the tax will be 6.15% of the first $6,600.00 of income and this tax will increase gradually to 7.8% of the first $6,600.00 of income. This means the tax on physicians for the year 1966 will amount to $405.90 for their inclusion under Social Security.

I want to urge the membership to carefully review the reports of all the bodies of the association so that you may have full and complete knowledge of the many varied activities in which your association is engaged.

A note of appreciation is certainly due the many members of your association who are actively engaged in looking out for the welfare of not only the physicians, but of your patients. These men are devoting many hours to the affairs of your organization and too much cannot be said in their behalf for the outstanding work which they are doing.

Like everything else, the activities of your association are continuing to grow and we are daily becoming involved in other matters which were unheard of a few short years ago.

I want to express my personal appreciation to the officers and members of the committees and commissions for their untiring efforts and to the staff for carrying out their many varied responsibilities.

JAMES A. WAGGENER, *Executive Secretary*

## Treasurer

The following is an itemized statement of the funds, including securities, of the association as of July 31, 1965.

SUMMARY OF ALL FUNDS:

| Fund | July 31 Cash | Investment Securities | Total |
|---|---|---|---|
| General Fund | $ 7,557.75 | $191,435.31 | $198,993.06 |
| Journal Fund | 482.46 | 5,000.00 | 5,482.46 |
| Medical Defense Fund | 587.13 | 35,000.00 | 35,587.13 |
| Building Fund | 877.57 | 5,000.00 | 5,877.57 |
| Student Loan Fund (old) | 2,947.03 | 3,564.69 | 6,511.72 |
| Kitchen Fund | — | 1,223.44 | 1,223.44 |
| | $12,451.94 | $241,223.44 | $253,675.38 |

With the general fund total assets of $198,993.06 as of this date, the obligations against this fund amount to $110,743.99; $15,000 is the money which has been loaned the association by the old Student Loan Fund; $49,551.99 is the money that has been set aside for operating expenses for the first quarter of the next fiscal year; $46,192.00 is money being held in escrow to make the payment to AMA-ERF under the new Guaranteed Student Loan Fund and the money held out for the first quarter fiscal year operation of *The Journal*. The payment for AMA-ERF will amount to $10,120.00; the money for the Guaranteed Student Loan Fund amounts to $19,120.00 and money held for the first quarter operation of *The Journal* is in the amount of $7,952.00. Subtracting these obligations from the assets of the general fund, it leaves net assets of $88,249.27.

The Executive Committee and the Council have reviewed the investment portfolio of the association

at each of their meetings and the treasurer has followed the recommendations of these bodies by investing all available cash in short term bills or in savings accounts in order to accumulate as much interest as possible while the funds are not required for current purposes.

The certified audit of Wolf and Company for the fiscal year ending September 30, 1965 was not completed in time for publication in this report, however, this firm of accountants prepares a quarterly statement and the statement for the period ending June 30, which is the third quarter of the fiscal year, is printed below. We are hopeful that the final itemized audit for the current fiscal year will be available for the reference committee at the time of the convention. The final audit for the fiscal year will be published with the proceedings of the House of Delegates in the December, 1965, issue of *The Journal.*

OTTIS N. OLVEY, M. D., *Treasurer*

## INDIANA STATE MEDICAL ASSOCIATION

### BALANCE SHEET

(Without Audit)

June 30, 1965

Exhibit A

### ASSETS

| | | | |
|---|---|---|---|
| *General Fund:* | | | |
| Cash | | 25,122.94 | |
| Deposits: | | | |
| Postmaster | | 944.13 | |
| Airlines | | 425.00 | |
| Prepaid expense | | 1,304.40 | |
| Accrued interest receivable | | 971.48 | |
| Receivable from other funds: | | | |
| The Jaurnal | 2,404.15 | | |
| Student Laan Fund | 6,435.31 | 8,839.46 | |
| Due fram Canference of Presidents | | 14.99 | |
| Reimbursement due for Medicare expenses | | 6,347.61 | |
| Investment in United States obligatians at cost, less amartization: | | | |
| Treasury bonds | 60,000.00 | | |
| Treasury bills and certificates af deposit | 145,000.00 | | |
| | 205,000.00 | | |
| Amortization of premium and discount (net) | 221.08 | 204,778.92 | |
| Savings and Loan shares | | 21,362.85 | |
| Fixed assets: | | | |
| Office furniture and equipment | 74,774.81 | | |
| Less accumulated depreciation | 27,849.80 | 46,925.01 | 317,036.79 |
| *Building Fund:* | | | |
| Cash | | 3,887.57 | |
| Due from General Fund | | 5,000.00 | |
| Fixed assets: | | | |
| Building | 299,354.38 | | |
| Less accumulated depreciation | 19,176.05 | 280,178.33 | |
| Land | | 69,187.60 | 358,253.50 |
| *The Journal:* | | | |
| Cash | | 5,733.22 | |
| Accounts receivable | | 6,325.44 | |
| Dues held in investment escrow | | 7,924.00 | 19,982.66 |
| *Medical Defense Fund:* | | | |
| Cash | | 327,42 | |
| Accrued interest receivable | | 528.13 | |
| Due from General Fund | | 5,243.75 | |
| Investment in U.S. Gavernment abligations | 30,000.00 | | |
| Unamartized band premium | 192.31 | 30,192.31 | 36,291.61 |
| *Student Loan Fund:* | | | |
| Cash | | 2,465.03 | |
| Deposits held in escraw | | 20,810.00 | |
| Notes receivable | | 20,053.47 | |
| Due from General Fund | | 19,080.00 | |
| Loans to General Fund | | 18,564.69 | 80,973.19 |
| *Medicare Fund:* | | | |
| Cash | | 60,021.00 | |
| Payments fram doctars | | 55.00 | 60,076.00 |

NOTE: Savings and Loan shares, including dividends in tatal amount af $21,362.85 have been allacated far the purpose of liquidating the abligatian ta the American Medical Educatian Fund.

### LIABILITIES AND FUND SURPLUS

| | | | |
|---|---|---|---|
| *General Fund:* | | | |
| Accounts payable: | | | |
| Operating expenses | | 640.72 | |
| American Medical Educatian Fund | | 19,080.00 | |
| Payable ta other funds: | | | |
| Medical Defense | 5,000.00 | | |
| Student Loan | 19,080.00 | 24,080.00 | |
| Allocated dues withheld far investment: | | | |
| Building Fund | 5,000.00 | | |
| The Jaurnal | 7,924.00 | | |
| Capital additians | 15,912.72 | 28,836.72 | |
| Accrued payroll taxes | | 287.43 | |
| Special advertising campaign | | 10,716.74 | |
| Deferred income: | | | |
| Unearned dues | 114,721.14 | | |
| Annual meeting revenue | 8,097.50 | 122,818.64 | |
| Deposits on tape recardings | | 411.50 | |
| Fund surplus (Exhibit B) | | 110,165.04 | |
| | | | 317,036.79 |
| *Building Fund:* | | | |
| Loans from members | | 23,975.00 | |
| Notes payable — bank | | 39,000.00 | |
| Fund surplus (Exhibit B) | | 295,278.50 | |
| | | | 358,253.50 |
| *The Journal:* | | | |
| Accaunts payable | | 5,625.71 | |
| Due to General Fund | | 2,404.15 | |
| Excess of revenue and expenditures (Exhibit D) | | 11,952.80 | 19,982.66 |
| *Medical Defense Fund:* | | | |
| Fund surplus (Exhibit B) | | 36,291.61 | 36,291.61 |
| *Student Loan Fund:* | | | |
| Due to General Fund | | 25,000.00 | |
| Fund surplus (Exhibit B) | | 55,973.19 | 80,973.19 |

| | | |
|---|---|---|
| *Medicare Fund:* | | |
| Payments to doctors | 76.00 | |
| Advanced by U.S. Government | 60,000.00 | 60,076.00 |

## STATEMENT OF FUND SURPLUS
(Without Audit)

For the Nine-month Period Ended June 30, 1965

Exhibit B

| | | |
|---|---|---|
| *General Fund:* | | |
| Balance, September 30, 1964 | | 98,981.27 |
| Cancellation of prior year dues liability to American Medical Education Fund | | 250.00 |
| | | 99,231.27 |
| Excess of revenues over expenditures (Exhibit C). | 22,886.57 | |
| Less portion attributed to Journal operations. | 11,952.80 | 10,933.77 |
| Balance, June 30, 1965 | | 110,165.04 |
| *Building Fund:* | | |
| Balance, September 30, 1964 | | 281,074.29 |
| Revenues: | | |
| Dues allocated | 19,145.00 | |
| Donations from members | 1,184.00 | 20,329.00 |
| | | 301,403.29 |
| Less: | | |
| Depreciation of building. | 4,466.21 | |
| Interest on bank loan | 1,658.58 | 6,124.79 |
| Balance, June 30, 1965 | | 295,278.50 |
| *Medical Defense Fund:* | | |
| Balance, September 30, 1964 | | 33,068.55 |
| Revenues: | | |
| Dues allocated | 4,859.00 | |
| Interest earned | 482.21 | 5,341.21 |
| | | 38,409.76 |
| Expenditures: | | |
| Attorney fees | 2,092.50 | |
| Office supplies and printing | 25.65 | 2,118.15 |
| Balance, June 30, 1965 | | 36,291.61 |
| *Student Loan Fund:* | | |
| Balance, September 30, 1964 | | 54,387.83 |
| Less 1964 dues allocation receivable cancelled by House of Delegates | | 18,945.00 |
| | | 35,442.83 |
| Revenues: | | |
| Allocation of 1965 dues. | 19,080.00 | |
| Donation received | 1,000.00 | |
| Interest earned | 450.36 | 20,530.36 |
| Balance, June 30, 1965 | | 55,973.19 |

## STATEMENT OF REVENUES AND EXPENDITURES
(Without Audit)

For the Nine-month Period Ended June 30, 1965

Exhibit C

| | Actual | Budget | Actual Over (Under) Budget |
|---|---|---|---|
| *Revenues:* | | | |
| Dues | 222,922.86 | 272,370.00 | (49,447.14) |
| Less dues allocated: | | | |
| Capital expenditures | 15,912.72 | 15,000.00 | 912.72 |
| Building Fund | 19,145.00 | 18,000.00 | 1,145.00 |
| The Journal | 31,860.00 | 28,800.00 | 3,060.00 |
| Medical Defense Fund | 4,795.25 | 4,320.00 | 475.25 |
| Student Loan Fund | 19,080.00 | 18,000.00 | 1,080.00 |
| American Medical Education Fund | 19,120.00 | 18,000.00 | 1,120.00 |
| | 109,912.97 | 102,120.00 | 7,792.97 |
| Dues available for operations | 113,009.89 | 170,250.00 | (57,240.11) |
| Interest received on investments | 5,328.30 | 3,400.00 | 1,928.30 |
| Received from AMA | 1,527.07 | 1,600.00 | ( 72.93) |
| Contributions | 1,500.00 | — | 1,500.00 |
| Restoration of prior allocation, Student Loan Fund | 18,945.00 | 18,990.00 | ( 45.00) |
| Total revenues | 140,310.26 | 194,240.00 | (53,929.74) |
| *Expenditures:* | | | |
| Committees and commissions (Schedule C-1) | 10,689.81 | 25,950.00 | (15,260.19) |
| Officers and Council (Schedule C-2) | 15,950.21 | 23,000.00 | ( 7,049.79) |
| Headquarters office (Schedule C-3) | 90,805.61 | 129,750.00 | (38,944.84) |
| Donations | 2,175.00 | 3,000.00 | ( 825.00) |
| Employees' retirement fund | 7,925.26 | 7,500.00 | 425.26 |
| Loss (profit) on Journal operations | ( 11,952.80) | 900.00 | (12,852.80) |
| Net loss — annual meeting. | 1,831.05 | — | 1,831.05 |
| Total expenditures | 117,423.69 | 190,100.00 | (72,676.31) |
| Excess of revenues over expenditures | 22,886.57 | 4,140.00 | 18,746.57 |

## STATEMENT OF OPERATING EXPENDITURES
(Without Audit)

For the Nine-month Period Ended June 30, 1965

Schedule C-1

### COMMITTEES AND COMMISSIONS

| | Actual | Budget | Actual Over (Under) Budget |
|---|---|---|---|
| *Standing Committees:* | | | |
| Grievance | 65.08 | 250.00 | ( 184.92) |
| Student Loan | 44.49 | 100.00 | ( 55.51) |
| *Commissions:* | | | |
| Constitution and Bylaws | 231.20 | 300.00 | ( 68.80) |
| Inter-Professional Relations | 329.30 | 300.00 | 29.30 |
| Legislation | 1,011.54 | 500.00 | 511.54 |
| Public Health | 424.90 | 500.00 | ( 75.10) |
| Public Information | 138.00 | 500.00 | ( 362.00) |
| Special Activities | 198.40 | 500.00 | ( 301.60) |
| Voluntary Health Agencies | 270.12 | 500.00 | ( 229.88) |
| Medical Economics and Insurance | 383.50 | 500.00 | ( 116.50) |
| Medical Education and Licensure | 756.89 | 500.00 | 256.89 |
| Planning | — | 500.00 | ( 500.00) |
| Governmental Medical Services | 484.08 | 500.00 | ( 15.92) |
| Aging | 285.43 | 500.00 | ( 214.57) |
| Education | 4,950.44 | 15,000.00 | (10,049.56) |
| Contingencies | 1,116.44 | 5,000.00 | ( 3,883.56) |
| | 10,689.81 | 25,950.00 | (15,260.19) |

Schedule C-2

## OFFICERS AND COUNCIL

| | Actual | Budget | Actual (Over) Under Budget |
|---|---|---|---|
| President | 284.43 | 1,500.00 | (1,215.57) |
| President-elect | 192.96 | 500.00 | ( 307.04) |
| Council chairman | — | 300.00 | ( 300.00) |
| AMA meetings | 12,448.96 | 15,000.00 | (2,551.04) |
| Treasurer — auditing | 1,175.00 | 1,500.00 | ( 325.00) |
| Council meetings | 1,789.64 | 3,000.00 | (1,210.36) |
| Executive Committee meetings | 59.22 | 1,200.00 | (1,140.78) |
| | 15,950.21 | 23,000.00 | (7,049.79) |

Schedule C-3

## HEADQUARTERS OFFICE

| | Actual | Budget | Actual Over (Under) Budget |
|---|---|---|---|
| Salaries | 51,706.27 | 90,000.00 | (38,293.73) |
| Supplies | 3,250.51 | 2,000.00 | 1,250.51 |
| Telephone and telegraph | 4,841.60 | 6,000.00 | ( 1,158.40) |
| Postage | 2,922.91 | 5,000.00 | ( 2,077.09) |
| Printing and stationery | 995.82 | 3,000.00 | ( 2,004.18) |
| Travel and entertainment | 5,804.60 | 9,000.00 | ( 3,195.40) |
| Building operations and utilities | 4,649.65 | 6,500.00 | ( 1,850.35) |
| Organization memberships | 720.87 | — | 720.87 |
| Insurance: | | | |
| Hospitalization | 3,823.72 | 1,500.00 | 2,323.72 |
| Other | 2,446.15 | 3,000.00 | ( 553.85) |
| Extra help | 618.53 | — | 618.53 |
| Payroll taxes | 1,486.84 | 2,250.00 | ( 763.16) |
| Maintenance — office machines | 747.96 | 1,000.00 | ( 252.04) |
| Depreciation | 5,275.11 | — | 5,275.11 |
| Unallocated | 1,514.62 | 500.00 | 1,014.62 |
| | 90,805.16 | 129,750.00 | (38,944.84) |

Exhibit D

## STATEMENT OF REVENUES AND EXPENDITURES
(Without Audit)

For the Nine-month Period Ended June 30, 1965

Exhibit D

## THE JOURNAL

| | Actual | Budget | Actual Over (Under) Budget |
|---|---|---|---|
| *Revenues:* | | | |
| Subscriptions: | | | |
| Members | 31,860.00 | 28,800.00 | 3,060.00 |
| Non-members | 995.00 | 1,000.00 | ( 5.00) |
| Advertising | 21,826.28 | 30,000.00 | ( 8,173.72) |
| Other | 2,688.52 | 5,000.00 | ( 2,311.48) |
| Total revenues | 57,369.80 | 64,800.00 | ( 7,430.20) |
| *Expenditures:* | | | |
| Salaries | 9,112.97 | 13,000.00 | ( 3,887.03) |
| Office expense and postage | 284.23 | 600.00 | ( 315.77) |
| Printing | 27,093.66 | 40,000.00 | (12,906.34) |
| Engravings | 2,857.04 | 3,600.00 | ( 742.96) |
| Travel and meetings | 1,125.00 | 1,800.00 | ( 675.00) |
| Bulk mailing | 1,343.07 | 1,500.00 | ( 156.93) |
| Other publishing expense | 298.54 | 550.00 | ( 251.46) |
| Payroll taxes | 220.54 | 500.00 | ( 279.46) |
| Employee group insurance | 179.10 | 150.00 | 29.10 |
| Rent and electricity | 2,556.00 | 3,450.00 | ( 894.00) |
| Telephone and telegraph | 221.11 | 450.00 | ( 228.89) |
| Unallocated | 125.74 | 100.00 | 25.74 |
| Total expenditures | 45,417.00 | 65,700.00 | (20,283.00) |
| Excess of revenues over expenditures (expenditures over revenues) | 11,952.80 | ( 900.00) | (12,852.80) |

Exhibit E

## STATEMENT OF REVENUES AND EXPENDITURES
(Without Audit)

For the Nine-month Period Ended June 30, 1965

## MEDICAL DEFENSE FUND

| | | |
|---|---|---|
| *Revenues:* | | |
| Transfer of applicable portion of dues | | 4,859.00 |
| Interest earned—U.S. Government bonds | | 482.21 |
| Total revenue | | 5,341.21 |
| *Expenditures:* | | |
| Attorney fees | 2,092.50 | |
| Stationery and Printing | 25.65 | 2,118.15 |
| Excess of revenue over expenditures | | 3,223.06 |

Exhibit F

## STUDENT LOAN FUND

| | | |
|---|---|---|
| Cash balance, September 30, 1964 | | 12,925.46 |
| *Revenues:* | | |
| Collection of student loans | 6,653.90 | |
| Interest received | 450.36 | |
| Donation received | 1,000.00 | 8,104.26 |
| | | 21,029.72 |
| Loans to General Fund | | 18,564.69 |
| Cash balance, June 30, 1965 | | 2,465.03 |

## Chairman of the Council

The councilors of the Indiana State Medical Association have experienced a year full of developments and full of change. The Council has had many individuals come before it to discuss projects, to discuss ideals and to discuss many problems. All of the minutes of the Council's work have been published in *The Journal* in detail. We have continued the type of agenda which was initiated by Dr. K. O. Neumann. The budget was better understood by the councilors because of its excellent presentation in this booklet. The portrayal was done by Mr. Waggener and made the budget quite understandable. This we thought was a marked help and should be continued.

An attempt this year was made to have the commissions meet at the same time as the Council. While this proved to bring large numbers to the building and make more people aware of what was going on, it did make it difficult for the Council to hear any of the reports of the commissions and for the chairmen of the commissions to report to the Council. At the July meeting, the Council met with the chairman of each of the commissions and heard their reports. This required an extra evening meeting of the Council, but was well worthwhile. The chairman of the Council feels that this should be continued in order that both the commissions and the Council can understand one another's problems and that our business can be carried on at a more rapid rate.

The Council met in its first regular session at the close of the House of Delegates on October 15, 1964. At this time, by secret ballot, I was elected chairman of the Council for the year. Dr. Ralph Everly of Indianapolis and Dr. G. O. Larson of LaPorte were named to the Executive Committee.

### Midwinter Meeting, January 24, 1965

The Council met for its regular midwinter meeting January 24, 1965. There was full attendance at the meeting. President Joe Black gave a report on the many Wednesdays that had been spent with meetings on medical education and licensure, basically concerning licensure in Indiana. He noted that the AMA was going to meet on February 6, 1965 and hoped that our delegates would express our thoughts for us there. He felt that we should develop some sort of philosophy concerning the medical school. He expressed the desire that bills should be introduced in the legislature in regard to medical education in other areas as well as the school itself.

Dr. Donald Wood came before the Council and thanked the entire delegation for its work at the AMA. He also appeared as a member of the Council on Legislative Activities of the AMA, and discussed in detail the Kerr-Mills bill in view of the special meeting of the AMA House of Delegates. A resolution was brought forth resolving that the Indiana State Medical Association seek such adjustments as would include—(a) administration by health agencies instead of welfare agencies, (b) liberalization of eligibility requirements including that of age and, (c) simplified certification procedures through the elimination of the welfare investigations.

A second resolution was adopted which stated that the Indiana State Medical Association urge that, if and when, in the opinion of the Indiana State Medical Association, passage of legislation such as H.R. 1 and S. 1, that the association make every effort to see that (a) support of the medical services provided by physicians are excluded from H.R. 1 and S. 1, and (b) services of physicians for those in need may be provided in any type of shelter appropriate to the need of the individual through the Kerr-Mills program, supported by general revenue, state and federal funds. The resolution further stated that the Indiana State Medical Association make a similar effort to see that tax wage funds in the King-Anderson Bill designated for provision of diagnostic services by physicians (i.e. radiologists and pathologists) be applied to more adequate nursing home care and special shelter services in the home. This was approved by the Council and these resolutions were to be sent to delegates of all 50 states.

The treasurer gave his report and stated that the organization was in the black.

Dr. Frank B. Ramsey, editor of *The Journal*, reported that *The Journal* showed a slight profit for the 12 months ending September 30, 1964. This he felt was in contrast with the report of the four largest state society journals in the United States for 1963.

Dr. Ramsey called attention to the questionnaire to be printed in the January *Journal* and asked that we appeal to all our constituent members to send this in. This would help advertising in the state *Journal*.

Dr. E. S. Jones reported on the delegates to the AMA and stated it was necessary for us to begin to send letters in support of Dr. Bibler's candidacy for Trustee of the AMA at the June meeting. Dr. Bibler was given 100% support.

Dr. Jones also called attention to the meeting of the AMA Congress on Occupational Health which will be held in conjunction with the annual meeting of the ISMA in Indianapolis on October 12, 13 and 14, 1965, saying that he hoped this will be the best meeting in the 25-year history of the congress.

Dr. Bibler reported on the meetings of the AMA Board of Trustees.

Dr. Ralph Everly referred from the Executive Committee a request for approval to send the delegates to the AMA special meeting in February, and it was approved.

The membership by districts was outlined and is printed in the report of this meeting in the March, 1965, *Journal*. The Council expressed concern over drivers insurance for persons over 65, and the fact that many physicians were being called upon to underwrite the ability of individuals over 65 to drive safely. This matter was referred to the appropriate commission for study of all facets of this examination.

Dr. A. C. Offutt requested that Dr. Carl Huber explain in detail the maternal and infant care program whereby federal funds would be made available through the State Board of Health to communities in which the physicians voted to accept such funds. This program was accepted. Dr. Offutt then reported on the TB eradication program. He stated that the state medical organizaion needed to encourage physicians to report tuberculosis cases.

Dr. D. S. Megenhardt reported on the Blue Cross Board of Directors and said he felt that the board members who were physicians had better liaison this year and were working hard.

Mr. Lloyd J. Banks, director of Enrollment Division, Blue Cross-Blue Shield, said there would be need for an increase in membership fees and explained this in great length. He recommended that adjustments be made effective on the anniversary date of the association plan which is April 1, 1965.

The following committee and commission reports were reviewed at this meeting: the Student Loan Committee, the Grievance Committee, and the Blue Shield program for dental coverage was also discussed. The Commission on Legislation, headed by Dr. Dwight Schuster, chairman, discussed at great length the possibility of a new medical school, medical licensure, acceptance of National Board examinations, changes in foreign graduates' requirements, changes in licensing reg-

ulations to facilitate interns coming to Indiana, Medical Registration Board income and expenditures and many other effects of the state legislature. The Council noted with confidence the work of this commission and the many hours it was spending during the meeting of the Legislature.

Date for the spring meeting was set.

### Special Meeting, February 14, 1965

As a result of the special meeting of the AMA House of Delegates, the Council met in special session February 14, 1965 to consider the possibility of entering a bill in the legislature concerning extension of Kerr-Mills in Indiana. An amendment was brought forth through much study by the Council and considerable and long debate concerning this possible legislation and its effect.

The final motion read as follows: "that the Council of the State Medical Association go on record as supporting the program on Eldercare, as outlined by the AMA, and, in addition, the Council moves that a program to augment this program, incorporating the following features, be enacted:

"(1) That we shall have some form of insurance for the elderly (over 65) in Indiana that will be underwritten by an insurance carrier, either commercial or voluntary non-profit plans, or groups;

"(2) That it shall cover all facets of medical care, hospitalization, nursing home, drugs, dental care and physicians' services currently encompassed in the Kerr-Mills law, and that these services shall be on a free choice basis;

"(3) That this plan shall be contingent upon individual need as outlined by, as yet, an undetermined income level, and

"(4) That as a matter of principle, to be used in any future negotiations on a contract with state government for the provisions of these services to the needy elderly being based upon a fee schedule based on the usual and customary fees in the locality."

### Spring Meeting, April 4, 1965

The Council opened its spring meeting on April 4, 1965, at the headquarters building.

The Council took the following actions—the problem of the transfer of fees for radiology and pathology services from Blue Cross to Blue Shield was reviewed. The Council authorized the attorneys for the state medical association to go ahead with this in any manner that they saw fit.

Dr. Black commented on the progress of the state association to this date stating that the Junior-Senior Day was a very excellent program the weekend before. He mentioned the Michigan Plan on the Association of Professions and asked that we study it. He asked that the councilors be sure that the physicians were better informed in their counties and districts. He stated that communications still seemed to be quite a problem. He complimented Dr. Irwin on being made our dean, and felt that we had a fine friend and excellent man as dean.

He stated that he thought we should be aware of third parties interest in our fee schedules. He felt that we no longer as a state organization can defend anyone charging excessive fees. He announced that Dr. Appel, president-elect of the AMA, would speak at Alumni Day at the University.

Dr. K. O. Neumann, president-elect, requested that the doctors begin to think about the appointments to the various commissions which were due in the fall. He said there are a lot of vacancies and he can use considerable help; he hoped that new blood could be pumped into a few of the commissions but that he wished to adhere strictly to the Constitution in the appointment of these commission members.

Dr. Ottis N. Olvey reported on the bank balance, stating that the building loan is now down to $39,000. He also showed us to be in good financial status.

Dr. Frank Ramsey stated that *The Journal* was doing well and that advertising had been increasing slowly. He stated that the returns on the readership survey were excellent.

Dr. Glenn W. Irwin, Jr., dean, Indiana University School of Medicine, reported for the first time. He reported on those items which he felt were the highlights of the educational goals of the university. He felt that we should have a major overhauling of the present curriculum; that the fields of postgraduate education and continued medical education were problems at the University and should be continued diligently. He stated that they were moving along fairly well with the problems of hospital space, but certainly more was needed. He pledged his support to the ISMA, and asked that we come to him with our problems concerning the school of medicine and the state association.

Dr. Bibler reported from the AMA Board of Trustees. He requested that some of the councilors attend the World Medical Association Meeting in London in September, 1965. He felt that participation by members of the AMA would help this organization. He stated that the AMA disability insurance would have to be reviewed at the next meeting. He spoke on legislation that was pending.

Dr. Ralph Everly presented a recommendation from the Executive Committee concerning the problem of government fees and the Council decided to present a resolution to the House of Delegates stating as a policy that the physician shall receive the usual customary fees as normally charged in his particular community when dealing with governmental payment programs. This resolution was to be presented to the Council at its July meeting by Dr. Edwards.

Interviews of Indiana physicians by a Columbia University study were discussed at great length. The Council approved the recommendation of the Executive Committee that in the future, the as-

sociation should not approve any survey until it has all the facts and is fully aware of what the survey might encompass.

Dues of four members were remitted because of hardship or illness.

Dr. Robert H. Rang discussed the proposal presented to the Daviess County Hospital by the United States Steel Company to build a 48-bed nursing home. He discussed this problem, but no action was taken by the Council.

Three members were nominated for vacancies on the Editorial Board—Dr. Alvin J. Haley of Fort Wayne, Dr. Richard Hawkins, Bedford and Dr. Franklin F. Premuda of Hammond. The Council will vote for two of these nominees at the fall meeting.

Note was also taken that new members should be nominated from various districts for the Blue Shield Board of Directors. Drs. Bernard D. Rosenak, E. T. Edwards, Lowell I. Thomas and Maurice E. Glock were nominated for Blue Shield Board members-at-large. The Council elected to delay the election on these Blue Shield Board members until the January, 1966, Council meeting.

Dr. A. C. Offutt reported in detail concerning the area-wide planning program, and brought the Council up to date on the progress or lack of progress the State Board of Health has made concerning this program. The Council moved to support Dr. Offutt in this program.

Dr. Lester H. Hoyt, member of the Professional Advisory Committee of Blue Cross, reported that all members of the Board of Directors had been re-elected and that the officers had been re-elected. He stated that there had been a gain of membership, that the organization has been operating in the black and now has reserves of approximately 95% of the recommended amount.

Dr. Bibler reported on the Student Loan Committee and requested that some type of letter be sent to those men who were delinquent in the old Student Loan funds. It was moved that Mr. Hollowell be authorized to send certified letters to the nine physicians who were delinquent in the repayment of their Student Loan requesting payment.

Dr. Don Taylor reported as Council liaison to Blue Cross. He stated that there is a special committee on Proposed Hospital Rate Increases in existence. He felt that a physician member should be made a member of this committee. This feeling was approved by the Council.

Dr. Mader reported on Commission on Convention Arrangements activities at quite some length.

Dr. Dwight Schuster, chairman of the Commission on Legislation, thanked the members of the Council, the executive secretary and the field men for the tremendous amount of work which they had done during the last General Assembly. He reported that at least 120 bills were reviewed by the Commission on Legislation and approximately 50 bills were followed intensively by the commission and the field men.

Dr. H. C. Ochsner reported on the Commission on Special Activities stating that the commission had discussed the impartial medical witness plan which had been proposed by the State Bar Association, and the commission was awaiting further suggestions from the Bar Association.

### Summer Meeting, July 17, 1965

The Council met at 6:00 p.m., Saturday, July 17, 1965, at which time they heard from the various committees and commissions of the association concerning their work, the accomplishments they have brought about during the year and any problems they wished to bring to the Council for policy decisions.

This meeting, I feel, proved very fruitful to not only the commission and committee chairmen, but also to the members of the Council, as it provided the Council with an opportunity to know more of the work being carried on in the association, and at the same time gave the chairmen an opportunity to discuss their programs with the Council.

The Council convened in regular session at 9:00 a.m., Sunday, July 18, in the Headquarters' building, at which time the Council reviewed the progress that had been made in the transfer of professional services from Blue Cross to Blue Shield program.

The Council also approved a resolution, presented by Dr. Edwards and his committee for submission to the House of Delegates in October.

The Council heard the reports of the president, president-elect, treasurer and editor of *The Journal*, and had a review of the June meeting of the AMA, presented by the delegates from the Indiana State Medical Association.

The Council took note of the illness of Dr. E. S. Jones, and instructed the association to send an appropriate message to Dr. Jones, wishing him a speedy recovery.

The Council also voted to recommend to the Board of Trustees of the AMA, the name of Dr. Guy A. Owsley as a nominee for the Council on Medical Service of the AMA.

The problem of communication and how to bring about an understanding on the part of every physician of current problems and programs of the association was discussed at length and it was decided that the councilor should attempt, if possible, to establish meetings with the delegates of the various counties within his district for a full discussion of these matters.

The Council, for the first time in many years, had two grievance matters brought before it, inasmuch as the Council also constitutes the Judicial Review Committee of the association. Complainants were heard in both cases and were requested to submit in writing their complaints for further study by the Council.

The Council heard the report of Dr. Offutt, Secretary of the Board of Health; report of Dr. Stangle, Professional Advisory Committee of Blue Cross; also reports from the Council Liaison Committee with Blue Shield, Indiana University School of Medicine and Blue Cross.

This meeting of the Council, perhaps, set a record for being one of the longest sessions of the

Council in several years, but I believe that the councilors would concur in that the time was well spent and that the additional hours of the meeting provided ample opportunity for the councilors to thoroughly discuss the many matters which came before it.

There being no further business, the meeting was adjourned to meet again on Monday, October 11.

The above report constitutes the actions taken by the Council since the last years meeting. This is not intended to be a detailed report, as these appear in the minutes within *The Journal* over the past year.

I would like to take this opportunity to express my thanks to the staff of the headquarters for their extreme help in the past year. The Indiana State Medical Association is indeed rich with an able, willing and devoted staff. Without those members who give so freely of their time above and beyond the necessity required of any other physician are indeed a great asset to the Indiana State Medical Association.

I would also like to thank the officers and councilors for their patience with me in the past year, and wish to call attention to the membership, that these men have given unselfishly of their time and efforts for each of us. It has been a pleasure as well as a distinct honor to have served as Chairman of the Council this past year. For this opportunity to be of service to my fellow physicians, I am most grateful.

EUGENE S. RIFNER, M.D., *Chairman*

## First Councilor District

The First District annual meeting at the Evansville Country Club on May 20, 1965 was well attended by members and their wives. Mead Johnson and Company were hosts for a social hour preceding the dinner. Dr. Ralph V. Everly, chairman of the Executive Committee, gave a brief talk following the dinner. Mr. John Peters of Bloomington, a career officer of the U. S. Department of State, spoke on "Relations of the U. S. with Eastern Europe."

Dr. George W. Willison, Blue Shield director, reported to the society. Dr. John D. Wilson discussed the preceptor program of Indiana University School of Medicine.

The following officers were elected:

Eugene W. Austin, M.D., President; Wallace M. Adye, Jr., M.D., Vice-President; Roland E. Weitzel, M.D., Secretary-Treasurer; Mr. Arthur P. Tiernan, Executive Secretary.

PATRICK J. V. CORCORAN, M.D., *Councilor*

## Second Councilor District

The annual meeting of the Second District Medical Society was held June 10, 1965 at the Sullivan Country Club. District President Joe Dukes and the Sullivan County Medical Society hosted the most outstanding meeting of the district in recent years.

M. E. Garrett, M.D., Baylor University, was the afternoon speaker. His paper on "Recent Advances in Vascular Surgery" was well received by a large group of interested physicians. The evening speaker, Paul Williamson, M.D., Bellaire, Texas gave an inspiring presentation on "AMDoc and Some of Its Mexican Clinics." ISMA President Black led a team of Bob Amick, ISMA field representative, and James Imboden, AMPAC field representative, in a discussion of current legislative problems facing American medicine. Herb Dixon reviewed Blue Shield progress and accomplishments in Indiana.

Phil Fox, M.D., was re-elected to the Blue Shield Board and given the added honor of next year's district presidency. Daviess-Martin County Society will be host at Washington next year. Phil Holland, M.D., of Bloomington was re-elected alternate councilor for a three-year term. Dr. J. S. Brown will continue as district secretary.

The members of the district society wish to thank Dr. Dukes and his colleagues in Sullivan County Society for putting new life into the district meeting.

E. T. EDWARDS, M.D., *Councilor*

## Third Councilor District

The Third District annual meeting was held at the Moose Club in Jasper, Indiana on May 26th. The attendance was very sparse but the food was excellent. George Lukemeyer, M.D., of the Indiana University Medical Center, presented a paper on peritoneal diastalsis.

Amongst the guests were Joe Black, M.D., of Seymour, president of the Indiana State Medical Association and Mr. James Waggener of the ISMA.

John Paris, M.D., of New Albany was re-elected as Blue Shield representative of the Third District and Marion L. Hagan, M.D., of French Lick was elected president of the district for 1966 with Orange County as host county for the meeting. The arrangements have not been completed.

There were no other major problems in the district since the last report.

D. M. KERR, M.D., *Councilor*

## Fifth Councilor District

The affairs of the Fifth District have gone along normally during the past year. No serious complaints have been brought to the attention of the councilor.

This year's Fifth District meeting was held on May 7th at the Terre Haute Country Club. This was a joint meeting with the Vigo County Medical Society and the Terre Haute Academy of Medicine, and it was well attended.

The scientific meeting consisted of very interesting talks by Dr. J. Stanley Battersby of Indianapolis and Dr. Paul M. Zoll of Boston, Mass. The Parke-Vermillion Medical Society will be host to the Fifth District in 1966. Elected as officers for the ensuing year are the following: Dr. John W. Somerville, Clinton, President. Also of Clinton,

Dr. Milton Herzberg—Vice-President and Dr. Robert M. Fell, Rosedale—Secretary-Treasurer.

V. EARLE WISEMAN, M.D., *Councilor*

## Sixth Councilor District

The Sixth District Medical Society held its annual meeting at the Greenfield Country Club, May 19, 1965, with the Hancock Medical Society as the host county.

After a morning of golf a Dutch treat luncheon was enjoyed.

The Indiana Academy of General Practice, in cooperation with the Eli Lilly and Company, sponsored the educational seminar for the meeting. This was held during the afternoon and following dinner. The afternoon scientific program was given by Dr. George Parker and Dr. George Belshaw, both of Indianapolis, who spoke on the topics "Allergy and Its Relationship to Pediatrics" and "Paracervical Block Analgesia During Labor," respectively.

Following the social hour and dinner they spoke again on the timely subjects: "Allergy and Its Relationships to Pediatrics," second half presentation and "The Rh Factor and Intrauterine Transfusion." All of the lectures were well received and appreciated by those attending.

Preceding the scientific session a short business meeting was held and the following officers elected:

Dr. William E. Murray, New Castle, President; Dr. John J. Farrell, Jr., Greenfield, Vice-President; Dr. Paul Inlow, Shelbyville, Secretary-Treasurer; Dr. Frank Green, Rushville, Blue Shield Board Member.

Dr. Walter U. Kennedy of New Castle, who had been the Blue Shield Board Member since its inception from this district, now holds Honorary Membership on the board.

The Sixth District Meeting will be held in May, 1966 in Shelbyville.

WILLIAM R. TINDALL, M.D., *Councilor*

## Seventh Councilor District

Members of the Seventh District Medical Society held their annual meeting at 6:30 p.m., Wednesday, May 5, 1965, in the El Dorado Country Club in Indianapolis, following an afternoon of golf and bridge.

Dr. Jay S. Reese, of Martinsville, was elected President-Elect of the Society and Dr. James S. Gosman, of Indianapolis, was re-elected Secretary-Treasurer.

Dr. Albert M. Donato, of Indianapolis, presided at the meeting and introduced guests of honor, including Dr. Lester D. Bibler, of Indianapolis, a trustee of the American Medical Association and Dr. Glen V. Ryan, of Indianapolis, president of the Board of Directors of Indiana Blue Shield, who spoke briefly.

Dr. Donato then introduced Dr. William C. Stafford, of Plainfield, incoming president, who then assumed office. Dr. Reese will succeed Dr. Stafford.

ALBERT M. DONATO, M.D., *Councilor*

## Eighth Councilor District

The Eighth District Medical Society met at the Delaware Country Club on June 2, 1965. Golf was enjoyed by many of the guests and members in the afternoon. This was followed by a social hour and dinner with approximately 75 members and guests in attendance. Dr. Karl L. Kauffman, Dean of the Pharmacy School at Butler University, gave a very informative and entertaining program on "Quackery."

The meeting was under the able direction of Dr. Warren Bergwall, president and Dr. David Dietz, secretary-treasurer. Dr. Glynn Rivers arranged the golf tournament.

At a short business meeting, Dr. Lowell Painter was elected president for 1966. Dr. Paul Sparks will serve as secretary-treasurer. The 1966 meeting will be sponsored by the Randolph County Medical Society and will be held at the Delaware Country Club on Wednesday, June 1, 1966.

Dr. Eugene Rifner, chairman of the Council, attended the meeting and spoke briefly to the members. Staff members from the state association and Blue Shield were also present.

No significant organizational or professional problems within the district came to the attention of the councilor during the year.

DONALD R. TAYLOR, M.D., *Councilor*

## Ninth Councilor District

The Ninth District had a very busy year but most of the business was confined to the activities of several of its component societies. The societies of action seem to be Tippecanoe, Clinton, Boone and Fountain-Warren. Of the remainder, one society fails to have a regular meeting of its members. It is felt that this is not conducive to a progressive policy on the part of its members and we must all be active and progressive in these times of danger to American medicine as we know it.

The members of the Ninth District are proud to have Dr. K. O. Neumann as president-elect and representative of the forward-looking members of the district. We are sure that he will continue to give greatly of himself during his term of office in 1965-66.

The Ninth District Medical Society meeting was held in Frankfort on May 21, 1965. The major result of the business meeting was the introduction and passage of a resolution by the host society to make the scientific portion of the Ninth District meeting an option of the host society rather than an obligation. Dr. Clarence Kern was elected alternate councilor to replace Dr. Albert Stouder. We wish to thank Dr. Stouder for his past endeavor and activities on the part of the members of the Ninth District and wish Dr. Kern all good luck in his new job. The next meeting of the district society will be in Fowler with Benton County as host society.

As councilor, I wish to urge all members of the district to be more active and involve themselves

more in the function of their component societies, their district society and their state association.

P. R. PETRICH, M.D., *Councilor*

## Tenth Councilor District

The Tenth District Society held two meetings during the past year, on October 21, 1964 at Phil Smidt's and on May 12th, 1965 at the "Trade Winds" Rehabilitation Center in Gary.

At the October 21st meeting, T. J. Smith, M.D., presided in the absence of the district president. L. H. Steen, M.D., Tenth District councilor, reported on the activities of the annual ISMA Convention of October 12-15th.

An election was held of the district officers, resulting in the re-election of Michael Shellhouse, M.D., as president and of E. J. Dierolf, M.D. as secretary.

Mr. Bartel Zandstra, representing the Democratic Party, and Mr. Arthur Endres, representing the Republican Party, separately presented their political party's views on "The National Scene."

The May 12th meeting was a combined meeting of the Tenth District Medical Society, the Tenth District of the Indiana Academy of General Practice and the four county societies in the Tenth District. The meeting was held at the "Trade Winds" Rehabilitation Center, a new facility owned by the Crippled Children's Society. Michael Shellhouse, M.D., president of the Tenth District Medical Society, conducted the meeting and announced that the speakers had been provided by the Indiana Academy of General Practice Road Show program.

During the afternoon, Dr. E. Clinton Texter of the Northwestern School of Medicine spoke on "Common Gastrointestinal Disorders." Dr. Charles R. Echt of Indiana University School of Medicine spoke on "The Importance and Methods of Detecting Early Female Genital Malignancy."

Following the scientific program, the physicians and their wives were taken on a tour of the center.

During the dinner, Lowell Steen, M.D., Tenth District Councilor, reported on the ISMA activities, and Joseph Sala, M.D., the IAGP Tenth District Councilor, discussed the academy activities. Mrs. Jackie Schilling, IAGP Executive Secretary, was introduced and appealed for more support of the academy program in the Tenth District.

Mr. Ted Dombrowski, executive director of the Crippled Children's Society, introduced his board members and also presented representatives of the Building Trades Unions who had built the center with labor donated by their members.

William Morris, district sales manager for the Continental Casualty Company, was introduced; as was Mr. Howard Grindstaff, field secretary for the ISMA, and Mr. Herb Dixon, physicians relations director for Indiana Blue Shield.

Dr. Shellhouse then conducted an election for the office of Tenth District councilor, resulting in the re-election of Dr. Lowell Steen.

Dr. Echt then spoke on "Indications for and Problems with Progestational Agents," and Dr. Texter spoke on "Adventures in the Alimentary Canal."

L. H. STEEN, M.D., *Councilor*

## Eleventh Councilor District

The Eleventh Medical District at the time of this printing will not have met. The district will meet September 15, 1965 in Peru. At this meeting they will elect the alternate councilor and a member of the Blue Shield Board. This meeting of the Eleventh District will be reported in a supplementary report as soon as the district has held its annual meeting.

EUGENE S. RIFNER, M.D., *Councilor*

## Twelfth Councilor District

The Twelfth District Medical Society held its annual meeting in Fort Wayne on May 19, 1965 with the Allen County Medical Society serving as host. Dr. Marvin E. Priddy, Fort Wayne, presided. The minutes of the meeting held May 21, 1964, and the treasurer's report were accepted as read. Dr. Mahlon F. Miller, Fort Wayne, gave a resume and report on the activities of Blue Shield; Dr. William R. Clark, Fort Wayne, gave the annual report on the activities of the alternate councilor and I gave the annual report of the councilor.

Distinguished guests at this meeting were Dr. Frank B. Ramsey, editor of *The Journal;* Dr. Lowell H. Steen, councilor of the Tenth District; Dr. Eugene S. Rifner, councilor of the Eleventh District and chairman of the Council; Dr. Kenneth O. Neumann, president-elect of ISMA; Mr. Frank Woolley, midwestern field representative of AMA; Mr. Richard Kilborn of Indiana Blue Shield and Mr. Howard Grindstaff, field representative of ISMA. All responded with short speeches at the invitation of the chair.

Election of officers followed and Dr. Warren L. Niccum, Columbia City, was elected president, Dr. Frederic L. Schoen, Fort Wayne, was re-elected vice-president and Dr. Kenneth F. Isenogle, Fort Wayne, was elected secretary-treasurer. Dr. William R. Clark, Fort Wayne, was re-elected to a three-year term as alternate councilor. May 18, 1966 was selected as the date for the next annual meeting. Fifty-eight members were in attendance at the business meeting. The meeting then was adjourned and a social hour and dinner was then enjoyed. The speaker of the evening was Glenn W. Irwin, Jr., M.D., Dean, Indiana University Medical School who spoke on "The Future of Medical Education in Indiana." This topic was well handled and the open discussion period which followed was informative and interesting. One hundred-thirty persons attended this portion of the program.

Again, the Twelfth District has enjoyed a good year and has increased somewhat in membership. The district has been represented at all regular and special meetings of the Council, usually by both the councilor and alternate councilor. At this time it is appropriate for the councilor to express his gratitude to all members of the district for

their cooperation and help during the past year and also to the alternate councilor, Dr. William R. Clark, who at all times has been most helpful in his elected role. Together we look forward to another successful year.

MILTON F. POPP, M.D., *Councilor*

## Thirteenth Councilor District

The annual meeting of the Thirteenth District, 1964, was held at Michigan City, Indiana, with Dr. Thomas Armstrong presiding. The minutes of the annual meeting were read and accepted, and the treasurer's report was approved. Reports were heard from Dr. G. O. Larson, member of the Executive Committee of the state association, and Dr. Jene Bennett, councilor of the Thirteenth District. The nominating committee proposed the following as a slate of officers, and they were unanimously elected:

Guy Ingwell, M.D., Knox, President; James Hurley, M.D., Elkhart, President-Elect; Cecil R. Burket, M.D., Bremen, Secretary-Treasurer; Robert Rouen, M.D., Elkhart, Alternate Councilor.

Sixty-two doctors and their wives attended the evening program which was given by Mr. Robert Mann of Michigan City, Indiana. The program was in support of preserving the Dunes as a state or national park.

The annual meeting for 1965 will be held on the afternoon and evening of Wednesday, September 29, in the Indiana Club at South Bend.

JENE R. BENNETT, M.D., *Councilor*

## The Journal

The financial affairs of *The Journal* have been satisfactory. The number of advertising pages has increased slightly as compared with last year, and may improve even more during the remainder of this calendar year. Expenditures have been maintained within the budget.

Responses to the Readership Survey (January issue) were generous and constructively critical. The Editorial Board and the associate editors will discuss the implications of these responses and determine to what extent changes should be made in the composition of *The Journal.* Proper use of our limited editorial and scientific space is even more important while the issue size is limited by paucity of advertising.

We continue to receive an adequate number of suitable and well written scientific and special articles. In fact, it has been necessary to decline acceptance of some worthy contributions in order to maintain our stock of papers at a near-suitable level. The waiting time between acceptance and publication is still longer than it should be. This will be improved by decreasing the supply of unpublished papers and by increasing the amount of advertising and advertising revenue.

FRANK B. RAMSEY, M.D., *Editor*

## Delegates to AMA

Indiana delegates to the American Medical Association convention, June 20-24, in New York City, played an important role in the proceedings this year.

Dr. Lester Bibler, Indianapolis, was re-elected to the 12-member Board of Trustees of the AMA for a three-year term.

Assignments to AMA Reference Committees went to Dr. Guy A. Owsley, Hartford City, and Jack E. Shields, Brownstown. Dr. Owsley served on the Public Health and Occupational Health Reference Committee and Dr. Shields on the Legislation and Public Relations Committee which considered the problem of "Medicare."

This latter committee's activity was lauded by the speaker of the house of the American Medical Association, Milford O. Rouse, and by the House of Delegates for the long hours of work, conscientious effort and resultant report to the house.

James A. Waggener, Executive Secretary of the ISMA, was re-elected secretary-treasurer of the Conference of Presidents and Officers of State Medical Associations, a position to which he has been elected for 12 consecutive years.

Resolution 49 on the payment of the fees under a government-sponsored medical care program was introduced by Indiana, and with some modifications, was adopted in its essentials by the American Medical Association's House of Delegates.

The final resolve of the Indiana resolution stated "That physicians inform all third parties that effective January 1, 1966, physicians will participate only on the basis that they receive their usual and customary fee for like services as paid for by the private paying patients."

During the discussion of this resolution on the floor of the House of Delegates, "usual" fee was defined as that fee usually charged for a given service by an individual physician to his private patient (i.e. his own usual fee).

"Customary" was defined as a fee within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county.)

An effort was made in the house to insert the term "reasonable" into the reference committee report on this resolution. Proponents defined "reasonable" fee as a "fee which meets the above two criteria, or in the opinion of responsible medical association's review committee, is justifiable, considering the special circumstances of the particular case in question.'

The Indiana delegation resisted insertion of the term "reasonable" based on what, they termed, would mean to some, lowering the fee. The term, they said, was subject to too broad an interpretation. Motion to amend the reference committee report to utilize the term "reasonable" was defeated.

The reference committee, which reviewed resolution 49 came out with this statement as a substitute for the Indiana resolution:

"It is recommended that when government

assumes financial responsibilities for an individual's health care, reimbursement for professional services should be on the same basis as in the case of other indispensable elements of health care. Therefore, reimbursement for the services of physicians participating in the government supported program should be on the basis of usual and customary fees."

Other items which came before the House of Delegates besides Federal health care legislation were the report of the President's Commission on Heart Disease, Cancer and Stroke; The Gundersen Committee report on organization of the House of Delegates and a plan for a new method of establishing AMA scientific sections.

Dr. Charles L. Hudson of Cleveland, Ohio, a member of the AMA Board of Trustees since 1961, was named president-elect of the association. He will take office as the 121st AMA president in June, 1966, succeeding Dr. James Z. Appel of Lancaster, Pa., who was inaugurated at the Sunday opening session of the house at the New York convention.

The 1965 AMA Distinguished Service Award was won by Dr. Tinsley R. Harrison of Birmingham, Ala., for his outstanding work in the field of cardiovascular diseases.

Final registration figures reached a grand total of 64,517, including 24,268 physicians, the largest physician registration in the association's history.

### Health Care Legislation

Most controversial issue before the house was that of nonparticipation under any so-called "Medicare" law that might be passed by Congress. This subject came up in various ways in nine resolutions and in portions of Dr. Appel's inaugural address.

The house recommended that "the members of the American Medical Association be reminded that it is each individual physician's obligation to decide for himself whether the conditions of a case for which he is about to accept responsibility permit him to provide his own highest quality of medical care."

In adopting a substitute resolution, the house declared that "the physicians of the United States of America pledge themselves to continue their search and activity, in whatever social environment may develop, to secure or to restore the freedom, high quality and availability of medical care which has been traditional in our country.

"When the fate of the pending medicare legislation is determined, this house will review, in special session if necessary, the effect of the law and take whatever action is deemed necessary.

"In keeping with the testimony before your committee, and the expressed policies of this house, this action should in *no way* be interpreted as a change in Section 6 of the "Principles of Ethics" of the American Medical Association which plainly states: 'A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care'; and that this House of Delegates reaffirm the principles of the Bauer amendment adopted in 1961.

"The House of Delegates reaffirm the nine principles for standards of health care programs as adopted by the House of Delegates in its special meeting February 7, 1965, and amended to read as follows:

'(1) No person needing health care shall be denied such care because of the inability to pay for it.

'(2) It is appropriate that government revenues be used to finance health care when other resources have been found to be inadequate.

'(3) Every level of government, municipal, conty, state and federal, should assume a responsible share in the financing of such programs.

'(4) The health care provided by such programs should be adequate and should be equal to that available to those who can afford to pay.

'(5) Maximum use should be made of voluntary prepayment and insurance mechanisms.

'(6) Administration of such program should be the responsibility of the state government. Participating states should be required to meet adequate standards of administration in order to qualify for federal funds.

'(7) Eligibility requirements for benefits should be fair, realistic, uncomplicated and practical.

'(8) Any such health care programs should provide funds only, and not direct services.

'(9) Funds for such programs may come from general tax revenues and not from social security taxes.' "

### Offer to President Johnson

In a related action, urging that government seek the advice of the medical profession on health legislation, the house adopted a resolution which included the following statements:

"This House of Delegates restates its offer to meet with the President of the United States through our Legislative Task Force to discuss proposed medical care legislation with a view to safeguarding the continued provision of the highest quality and availability of medical care to the people of the United States.

"The House of Delegates of the American Medical Association instruct the Board of Trustees of the American Medical Association to embark immediately on an active campaign to inform the membership of the American Medical Association of the grave considerations in adhering to our principles of ethics posed by legislation now pending before Congress.

"The American Medical Association strongly urge those branches of the government interested in the formulation, the enactment, and the implementation of laws which deal with the provision of professional medical services to the public to seek and utilize the advice and assistance of the

physicians who will render such services. Such advice and assistance should be received through our chosen representatives, the officers of the American Medical Association.

"The American Medical Association intensify its efforts to modify all such pertinent legislation, employing the necessary means and appropriate actions to the end that the health of the public and the pursuit of excellence in medicine be unimpaired by such legislation.

"The American Medical Association make every effort to continue, and where necessary, to expand its communication activities so that all physicians as members of component medical societies will be promptly, continuously and completely informed of developments in this critical area during the coming months."

### The DeBakey Commission Report

In considering seven resolutions involving the report and recommendations of the President's Commission on Heart Disease, Cancer and Stroke, the house adopted a substitute statement which resolved that:

"The American Medical Association point with pride to the immense strides made in the approaches to the conquest of heart disease, cancer, and stroke under existing patterns of research and medical practice; strongly favoring the use of available financial support for extension of these patterns rather than replacement by a complex of medical control centers and satellites.

"The American Medical Association oppose those particular commission recommendations which call for and have stimulated proposals for hastily contrived and unproven sweeping changes in the pattern of medical research, education and patient care.

"The component state medical associations be urged to conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care.

"The state medical associations be urged to report findings and recommendations resulting from these conferences to the AMA Board of Trustees, for the information of the board, its councils and the association members."

### The Gundersen Committee

Action on the Gundersen Committee report reviewing the size, make-up and functions of the House of Delegates was postponed until the 1965 Clinical Convention in Philadelphia.

The House adopted a reference committee report saying:

"It was apparent that if the organization of the House of Delegates of the American Medical Association, which is of paramount importance to the efficient and productive operation of the association, is to be thoroughly studied by the delegates, more time will be required."

The Gundersen Committee was appointed an ad hoc unit at the directive of the AMA House in June, 1963. The committee, which is chaired by Gunnar Gundersen, M.D., La Crosse, Wis., a past president of the AMA, brought in an extensive 35-page report.

The committee pointed out that certain aspects of its work were unfinished, particularly those dealing with the function of the AMA scientific sections. The AMA house action recommended that the committee continue its study of scientific sections.

### Organization of a New Section

In a report to the Board of Trustees, the Council on Postgraduate Programs affirmed its belief that the establishment of a new section is an important change in the AMA structure, and submitted a procedure for evaluating the qualifications for a new section and the scientific programs of all sections.

In brief, this procedure provides that (1) the group requesting formation of a new section submit to the executive vice-president a written request for approval; (2) the request be transmitted by the board to the Council on Postgraduate Programs for evaluation of the petition; (3) if approved by the council, a mandatory trial period of two years as presently in effect be provided under the auspices of the council; and (4) after such trial period, a recommendation for acceptance or denial of the petition for the establishment of a section be made to the board.

The house approved the recommendation, with certain word changes, and suggested that it be sent first to the Gundersen Committee and then to the appropriate AMA council for consideration.

### Miscellaneous Actions

In dealing with 73 resolutions and numerous reports from councils, committees and the Board of Trustees, the House of Delegates also:

Urged medical schools and agencies concerned with continuing education to incorporate "appropriate learning experiences" for physicians in counseling relating to sexual attitudes and behavior.

Agreed that hospital medical staffs and state and component medical societies be urged to encourage the establishment, maintenance and proper use of cancer registries in hospitals, but that the establishment of such registries should not be made a requirement for accreditation by the Joint Commission on the Accreditation of Hospitals.

Instructed the Council on Medical Service and its Committee on Federal Medical Services to "remain alert to any deviations from policies of the Veterans Administration concerning the provision of drugs to veterans treated by private physicians, and to meet with pharmacy representatives so that the basic principle of freedom of choice" of pharmacists be maintained

Referred to the Board of Trustees a resolution calling for the AMA to caution the public against discontinuing voluntary health insurance policies and prepayment plans for persons over 65 in "anticipation of pending legislation."

Reaffirmed its policy concerning the practice of radiology, pathology, anesthesiology and physical medicine as medical and not hospital practices.

Reaffirmed AMA policy that human blood, as living tissue, should not be purchased under insurance contracts. It was recognized that exceptions may be necessary when there is need for unusually large numbers of transfusions, or whenever volunteer blood donors are not available.

Urged state and local medical societies to encourage the development of the Explorer Scout Program for Medical Specialty Posts and noted that about 150 of the 21,000 Explorer Scout posts in the country are directly related to health.

Adopted a resolution calling for continued efforts to secure the passage of legislation "which will remove tax discrimination against professional people, specifically HR 10 (Keogh) and HR 697 (Weltner), but turned down recommendations that the AMA encourage its members to proceed at the state and county levels with the formation of corporations for the purpose of implementing an "organized effort in the courts to remove tax discrimination."

Directed the board to review the subject of federal assistance for operating expenses for health or medical education facilities.

Directed the board to study the opportunities and problems associated with Operation Head Start and other programs now operating or planned under the Economic Opportunity Act.

Referred to the board for study a resolution calling for "a program of purchase of health insurance . . . in every state, subsidy for which shall be by federal-state participation," under which "extension of coverage shall be to all needy persons regardless of age."

Also referred to the board for consideration and appropriate action a 10-point legislative program outlined by the Minnesota delegation.

The house received a series of resolutions urging approval of an American Board of Family Practice. All were referred to the Council on Medical Education.

Urged the Council on Medical Education to establish a standard date of appointment for all approved residency training programs.

Encouraged state and county medical societies to participate in the formation of State Associations of the Professions, "to provide a vehicle, for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit."

Amended the bylaws to provide that the vice-president shall succeed to the presidency should the president die, resign or be removed from office.

Accepted a Board of Trustees report stating that it had referred to the joint AMA-American Bar Association committee a previously introduced resolution designed to present a grievance against alleged abuse of legal processes, characterized in the resolution as "vexatious litigation."

### Opening Session

Dr. Appel, expressing his personal opinion in his inaugural address at the Sunday session, said that if the omnibus Medicare bill is passed by Congress, the medical profession must do all it can to develop the good points and eliminate the bad points of the law. He declared that, regardless of personal opinion, "we do not have the right—either as physicians or citizens—to violate a law or to violate the spirit of the law or its intent." Outgoing president Donovan F. Ward pointed out:

"If it were true that the public climate was the dominant factor affecting the decisions of those who make legislative history, we now would be winning both in the House and the Senate."

### Election of Officers

Dr. Hudson's unexpired term on AMA's Board of Trustees will be filled by Dr. Irvin E. Hendryson, Denver, Colo. Dr. Hendryson will serve until 1967.

Re-elected to the board for three-year terms were: Drs. J. B. Copeland, Austin, Texas; Gerald D. Dorman, New York and L. O. Simenstad, Osceola, Wisc.

W. Andrew Bunten, M.D., Cheyenne, Wyo., was elected to a one-year term as the association's vice-president.

Dr. Milford O. Rouse of Dallas, Texas, was re-elected Speaker of the House of Delegates, and Dr. Walter C. Bornemeier of Chicago was re-elected vice speaker.

Elected to the Council on Medical Education were Dr. Bland W. Cannon of Memphis, Tenn.; Dr. William R. Willard of Lexington, Ky. (to succeed himself) and Dr. Earle M. Chapman of Boston, Mass.

Named to the Council on Medical Service were Dr. C. A. Hoffman of Huntington, V. Va., and Dr. Russell B. Roth of Erie, Pa., who was re-elected unanimously. Dr. George D. Johnson of Spartanburg, S. C., member of the Council on Constitution and Bylaws, was also re-elected unanimously.

Dr. James H. Berge of Seattle, Wash., was named to succeed himself on the Judicial Council.

HAROLD C. OCHSNER, M.D.
E. S. JONES, M.D.
FRANCIS L. LAND, M.D.
GUY A. OWSLEY, M.D.
JACK E. SHIELDS, M.D.

# Reports of Committees

## Executive Committee

The Executive Committee met at the conclusion of the House of Delegates and Council meeting on October 15, 1964 for the purpose of organizing for its work for the coming year.

By secret ballot Dr. Ralph V. Everly was elected chairman; Dr. Ottis Olvey was welcomed as the treasurer; Dr. Lester Hoyt, assistant treasurer; and Dr. E. S. Rifner, chairman of the Council.

The report of the activities of the Executive Committee will necessarily be brief to conserve time as the minutes of the Executive Committee have been published regularly in *The Journal* in detail and copies of all the minutes are in the hands of the reference committee for their review.

Your committee has met every month for the purpose of handling the routine matters of the association. It has been an active year. In the November, 1964, meeting, the committee received a gift of $1,000 from former President M. A. Austin, M.D., to be applied toward the student loan fund. Your committee also went over some of the proposed legislation which was supposed to come before the General Assembly, scheduled to convene in January, 1965. Plans were finalized at this time for the meeting of the American Medical Association in Miami and the campaign to elect Dr. Don Wood as president-elect of the AMA.

In January, your committee instituted a series of sessions with the Pharmaceutical Association concerning activity of the pharmaceutical board in relation to physicians who were dispensing drugs. We also entered into an agreement with the property owner to the north of us to cut an access from our parking lot so cars can exit on 40th Street rather than on Meridian Street. Your committee also reviewed the projected special session of the delegates to the AMA and several commission matters.

In February, the auxiliary officers appeared before your committee to discuss their program for the coming year and to review the accomplishments made during the previous 12-month period. The committee voted to put a ceiling and central lighting in the basement area to make it more useable. We discussed the proposed program for the 1965 convention, reviewed the meeting of the AMA House of Delegates in its special session and planned for a special called meeting of the Council.

The committee met again on April 3rd for the transaction of routine matters and granted the request of the Convention Arrangements Commission for entertainment and honorariums for out-of-state speakers for the 1965 meeting. Also discussed was legislation before the Congress and the actions taken by the Indiana General Assembly. The committee granted the request of the Commission on Governmental Medical Services to make a study of contract arrangements between county medical societies and county departments of public welfare. The committee notified the director of the Indiana Employment Security Division that the fee which had been set for examinations by this department was not sufficient to pay for laboratory charges and recommended the department pay the doctor his usual and customary fee for such examinations. Plans were made for the appearance of Dr. James Z. Appel at the Indiana University Alumni Day and for the New York meeting of the American Medical Association, at which time the association would actively support the re-election of Lester D. Bibler, M.D., to the Board of Trustees.

The committee met again on May 15th, at which time, in addition to routine matters, H.R. 6675, the proposal for providing hospital and medical care through Social Security taxation, was reviewed. Several matters dealing with the activities of the Medical Licensure Board and the implementation of the 1965 laws were also reviewed. The committee noted the approval of the Council that the association should study the organization of the Association of Professions and this was referred to the Commission on Inter-Professional Relations. The committee received a suggestion that the association might institute an advertising campaign in *The Journal of the Student AMA* in the hopes of encouraging more interns to avail themselves of training at Indiana hospitals. The committee approved the employment, on a commission basis, of a local salesman in an effort to increase the advertising in *The Journal.*

Your committee met on June 20th in New York City, with the delegates and alternate delegates to the AMA, at which time the resolutions and reports to come before the AMA were reviewed and discussed and assignments of responsibilities were made to each member to follow several matters through the reference committees of the house. Also a resolution calling for payment of usual and customary fees by third parties was approved for introduction in the New York meeting of the AMA. Several convention matters were reviewed and physicians were selected to be in charge of the 50-Year Club members and to make responses on behalf of the 50-Year Club members. The request of the Hospital Association for appointment of a committee to discuss emergency room procedures was approved and the president was empowered to appoint such a committee. The resolution of the Academy of Ophthalmology and Otolaryngology was reviewed and referred to the state director of the Blind Assistance Program and the State Medical Licensure Board. The committee had a letter from the AMA concerning a situation developing in a northern county and the committee set in motion an investigation of this matter. The committee approved the participation in Indiana Health Careers, Inc., which is an organization set up among the various healing professions to encourage high school students to seek a career in one of the areas of the health services.

The committee last met, prior to the publication

of this report, on July 17 at which time, in addition to routine matters, the use of the legal counsel was discussed and referred to the Council. The committee also authorized payment of $3,000.00 additional toward the principal of the building loan, thereby reducing the loan to $36,000.00. In order to make the office of the president more dignified and meaningful, the committee approved and recommended to the Council that they also approve an oath of office and swearing-in ceremony for the incoming officers of the Indiana State Medical Association. A report was received on the various meetings which have been held concerning the new licensure laws by the state medical board. The committee also received a report of the action of the attorney general's office in defining the usual and customary fee, as provided for in the Kerr-Mills law in Indiana and authorized a letter of protest from the association.

As stated previously, the report is sketchy and is completed with the July 17 meeting in order to permit the report to be published in the handbook. The minutes of the meetings to be held in August and September cannot be published at this time but will be given to the reference committee for their review. These minutes will also have been published in *The Journal* of the Indiana State Medical Association.

### Medical Defense Activities

1. *Malpractice cases.* A year ago, at the time of this report, August 1, 1964, the following case was pending before the committee:

*Case No. 307* — Suit filed March 22, 1962. Pending.

Since August 1, 1964, and up to August 1, 1965, the following two cases have come before the committee, making three cases pending at this time as against one unclosed case at the same time last year:

*Case No. 308* — Suit filed March 10, 1965. Pending

*Case No. 309* — Suit filed December 10, 1964. Pending.

2. *Medical Defense Fund Statement from August 1, 1964 to August 1, 1965:*

| | | |
|---|---|---|
| Cash in Bank, August 1, 1965 | | $ 2,550.32 |
| Receipts: | | |
| Dues | $ 4,882.75 | |
| Interest | 969.71 | |
| | | 5,852.46 |
| Total Receipts | | $ 8,402.78 |
| Disbursements: | | |
| Supplies | $ 25.65 | |
| Attorneys' Retainer | 2,790.00 | |
| Investment (Bills) | 5,000.00 | |
| Total Disbursements | | $ 7,815.65 |
| Balance on hand, August 1, 1965 | | $ 587.13 |

### MEMBERSHIP REPORT

| | Dec. 31, 1964 | July 31, 1964 | July 31, 1965 | AMA, 1965 |
|---|---|---|---|---|
| *1st District* | | | | |
| Gibson | 15 | 15 | 15 | 14 |
| Perry | 11 | 11 | 9 | 9 |
| Pike | 4 | 4 | 4 | 4 |
| Posey | 10 | 10 | 10 | 10 |
| Spencer | 4 | 4 | 4 | 3 |
| Vanderburgh | 235 | 233 | 236 | 232 |
| Warrick | 7 | 7 | 7 | 7 |
| TOTAL | 286 | 284 | 285 | 279 |
| *2nd District* | | | | |
| Daviess-Martin | 19 | 19 | 20 | 18 |
| Greene | 16 | 16 | 16 | 9 |
| Knox | 39 | 39 | 38 | 36 |
| Owen-Monroe | 61 | 61 | 61 | 58 |
| Sullivan | 15 | 15 | 15 | 13 |
| TOTAL | 150 | 150 | 150 | 134 |
| *3rd District* | | | | |
| Clark | 41 | 41 | 39 | 39 |
| Dubois | 24 | 24 | 24 | 21 |
| Floyd | 37 | 37 | 37 | 36 |
| Harrison-Crawford | 12 | 12 | 11 | 11 |
| Lawrence | 23 | 23 | 23 | 21 |
| Orange | 9 | 9 | 9 | 9 |
| Scott | 4 | 4 | 4 | 3 |
| Washington | 7 | 7 | 7 | 7 |
| TOTAL | 157 | 157 | 154 | 147 |
| *4th District* | | | | |
| Bartholomew-Brown | 43 | 43 | 46 | 45 |
| Dearborn-Ohio | 20 | 20 | 20 | 19 |
| Decatur | 12 | 12 | 11 | 9 |
| Jackson-Jennings | 25 | 25 | 24 | 22 |
| Jefferson-Switzerland | 29 | 29 | 28 | 27 |
| Ripley | 8 | 8 | 9 | 7 |
| TOTAL | 137 | 137 | 138 | 129 |
| *5th District* | | | | |
| Clay | 12 | 12 | 11 | 11 |
| Parke-Vermillion | 25 | 25 | 23 | 23 |
| Putnam | 15 | 15 | 15 | 15 |
| Vigo | 119 | 117 | 119 | 119 |
| TOTAL | 171 | 169 | 168 | 168 |
| *6th District* | | | | |
| Fayette-Franklin | 17 | 17 | 16 | 16 |
| Hancock | 20 | 20 | 21 | 21 |
| Henry | 40 | 40 | 39 | 38 |
| Rush | 15 | 15 | 14 | 14 |
| Shelby | 19 | 19 | 20 | 19 |
| Wayne-Union | 74 | 73 | 67 | 64 |
| TOTAL | 185 | 184 | 177 | 172 |
| *7th District* | | | | |
| Hendricks | 24 | 23 | 22 | 22 |
| Johnson | 29 | 29 | 29 | 29 |
| Marion | 1067 | 1059 | 1053 | 1048 |
| Morgan | 17 | 17 | 18 | 18 |
| TOTAL | 1137 | 1128 | 1122 | 1117 |
| *8th District* | | | | |
| Delaware-Blackford | 116 | 112 | 122 | 117 |
| Jay | 16 | 16 | 15 | 14 |
| Madison | 96 | 96 | 101 | 96 |
| Randolph | 21 | 21 | 21 | 20 |
| TOTAL | 249 | 245 | 259 | 247 |
| *9th District* | | | | |
| Benton | 9 | 9 | 9 | 9 |
| Boone | 19 | 19 | 19 | 19 |
| Clinton | 18 | 18 | 20 | 20 |
| Fountain-Warren | 15 | 15 | 15 | 15 |
| Hamilton | 25 | 25 | 24 | 16 |
| Montgomery | 27 | 27 | 27 | 27 |
| Tippecanoe | 118 | 116 | 121 | 120 |
| Tipton | 11 | 11 | 11 | 11 |
| White | 12 | 12 | 11 | 11 |
| TOTAL | 254 | 252 | 257 | 248 |
| *10th District* | | | | |
| Jasper | 7 | 7 | 7 | 7 |
| Lake | 419 | 411 | 424 | 404 |
| Newton | 5 | 5 | 5 | 5 |
| Porter | 32 | 32 | 32 | 32 |
| TOTAL | 463 | 455 | 468 | 448 |

| | Dec. 31, 1964 | July 31, 1964 | July 31, 1965 | AMA, 1965 |
|---|---|---|---|---|
| *11th District* | | | | |
| Carroll | 9 | 9 | 8 | 8 |
| Cass | 38 | 38 | 37 | 37 |
| Grant | 71 | 71 | 68 | 67 |
| Howard | 67 | 67 | 68 | 68 |
| Huntington | 22 | 22 | 25 | 24 |
| Miami | 14 | 14 | 14 | 14 |
| Wabash | 25 | 25 | 25 | 24 |
| TOTAL | 246 | 246 | 245 | 242 |
| *12th District* | | | | |
| Adams | 14 | 14 | 14 | 14 |
| Allen | 290 | 287 | 291 | 288 |
| De Kalb | 20 | 20 | 23 | 23 |
| La Grange | 8 | 8 | 7 | 7 |
| Noble | 16 | 16 | 17 | 17 |
| Steuben | 13 | 13 | 14 | 14 |
| Wells | 37 | 37 | 37 | 39 |
| Whitley | 18 | 18 | 17 | 17 |
| TOTAL | 416 | 413 | 420 | 419 |
| *13th District* | | | | |
| Elkhart | 108 | 108 | 108 | 105 |
| Fulton | 12 | 12 | 11 | 9 |
| Kosciusko | 19 | 19 | 19 | 19 |
| La Porte | 101 | 101 | 100 | 98 |
| Marshall | 26 | 26 | 27 | 27 |
| Pulaski | 6 | 6 | 5 | 4 |
| St. Joseph | 235 | 233 | 236 | 236 |
| Starke | 6 | 6 | 7 | 7 |
| TOTAL | 513 | 511 | 513 | 505 |
| SUMMARY | | | | |
| 1st District | 286 | 284 | 285 | 279 |
| 2nd District | 150 | 150 | 150 | 134 |
| 3rd District | 157 | 157 | 154 | 147 |
| 4th District | 137 | 137 | 138 | 129 |
| 5th District | 171 | 169 | 168 | 168 |
| 6th District | 185 | 184 | 177 | 172 |
| 7th District | 1137 | 1128 | 1122 | 1117 |
| 8th District | 249 | 245 | 259 | 247 |
| 9th District | 254 | 252 | 257 | 248 |
| 10th District | 463 | 455 | 468 | 448 |
| 11th District | 246 | 246 | 245 | 242 |
| 12th District | 416 | 413 | 420 | 419 |
| 13th District | 513 | 511 | 513 | 505 |
| TOTAL | 4364 | 4331 | 4356 | 4255 |

## The Journal

**Advertising**

A continued economy has been effected in the operation cost of *The Journal* during the past year. Advertising from the national State Journal Advertising Bureau has shown a slight increase during the past 12 months but has not yet reached the figure of 1961-62. Local sales of advertising have shown an increase during the first six months of the year. There will no doubt be an additional increase in the next six months due to the employment, on a commission basis, of a local advertising solicitor.

The budget predicted a deficit of $900 for the current fiscal year but we are hopeful that *The Journal* will show a slight profit for the current operation.

This is a comparative report for the first six months of each year indicated.

| | 1962 | 1963 | 1964 | 1965 |
|---|---|---|---|---|
| State Journal Advertising Bureau | $21,538.08 | $16,782.08 | $13,474.13 | $13,927.88 |
| Sold Direct by Journal | 2,013.00 | 1,950.60 | 2,017.10 | 2,812.74 |
| Total | $23,551.08 | $18,732.68 | $15,491.23 | $16,740.62 |

**Printing Costs**

| Year | Cost | No. of Pages (Inserts excluded) |
|---|---|---|
| 1961 | $49,539.57 | 1868 |
| 1962 | 51,291.51 | 1862 |
| 1963 | 44,212.23 | 1612 |
| 1964 | 36,139.47 | 1456 |
| 1965 (6 months) | 17,482.10 | 690 |

| Year | Reading | % Reading | Adv. Pages | % Adv. Pages | Total Pages | Av. Pages per Issue |
|---|---|---|---|---|---|---|
| 1959 | 1226 | 53 | 1088 | 47 | 2314 | 193 |
| 1960 | 1413 | 61 | 919 | 39 | 2332 | 194 |
| 1961 | 1284 | 67 | 634 | 33 | 1918 | 160 |
| 1962 | 1308 | 68 | 604 | 32 | 1912 | 159 |
| 1963 | 1139 | 70 | 487 | 30 | 1626 | 135 |
| 1964 | 1051 | 71 | 423 | 29 | 1474 | 123 |

RALPH V. EVERLY, M.D., *Chairman*
J. M. BLACK, M.D.
K. O. NEUMANN, M.D.
E. S. RIFNER, M.D.
OTTIS N. OLVEY, M.D.
LESTER HOYT, M.D.

## Grievance

The Grievance Committee held meetings on November 15, 1964 and July 18, 1965.

As of July 18, 1965, 25 cases had been considered during the preceding 12 months. Seventeen cases were referred to the physician named in the complaint, eight were settled and nine remained unsettled. County medical societies accepted the adjudication responsibility for six cases, two were closed and four are not yet settled. The Indiana State Medical Association Grievance Committee was accordingly required to attempt the settlement of only eight cases out of the total of 25 originally referred, five cases are not yet concluded.

The ISMA Grievance Committee continued to follow the procedure of recent years. (1) Receipt of a complaint is acknowledged by a letter which states that action can proceed only after receiving the complainant's permission to forward a full copy of the complaint to the physician or physicians named therein along with identification of those filing the complaint. (2) Should the requested permission be received, the physician named is asked to attempt a personal settlement of the complaint. (3) Should the physician be unsuccessful or should he request that his county medical society attempt settlement, the matter is so referred with the ISMA Grievance Committee retaining responsibility as the rules governing it require. (4) If the county medical society declines adjudication, its efforts are unavailing or if more than one county medical society is involved, the ISMA Grievance Committee proceeds to seek satisfactory settlement. It will also assume adjudication responsibility if the physician or physicians involved make such a request.

It is important in maintaining effective function of the ISMA Grievance Committee that all county society grievance committees and county society secretaries abide by the 1962 House of Delegates

directive in reporting disciplinary action taken at the county level. Only in this way can the ISMA Grievance Committee be enabled to give more urgent attention to offenders who have previously hurt the public relations of the medical profession. It is the recommendation of the Grievance Committee that a copy of the annual report be sent to each county medical society grievance committee and the secretary of each county medical society.

The Grievance Committee thanks those ISMA members who have given it their splendid cooperation during the past year.

PHILIP B. REED, M.D., *Chairman*
MARVIN L. McCLAIN, M.D., *Vice-Chairman*
PAUL L. STIER, M.D., *Secretary*
RAYMOND E. NELSON, M.D.
EARL W. MERICLE, M.D.
GUY A. OWSLEY, M.D.
H. ALLISON MILLER, M.D.
WILLIAM R. CLARK, M.D.
MAURICE E. GLOCK, M.D.
WILLIAM H. NORMAN, M.D.

## Student Loan

The Student Loan Committee held six meetings during the past year. Twenty-seven applicants for loans were interviewed by the committee. Of these 27, 22 were approved for loans totaling $19,700.00. In addition, one applicant who was approved for a $1,000.00 loan withdrew his request as he found another source of income. One applicant was denied a loan of $1,000.00 because he did not maintain his residence in Indiana, and two applicants were refused loans of $750.00 and $300.00 respectively because the money was not to be used to further their medical education.

The Guaranteed Loan Plan became effective December 1, 1963, at which time the association entered into an agreement with the Indiana National Bank to make loans to students approved by the Student Loan Committee, with the student giving security to the bank. A summary of the operation of this Guaranteed Loan Fund follows:

| | | |
|---|---|---|
| | 18 loans granted December 1, 1963 to October 1, 1964, for a total of | $11,300.00 |
| | 22 loans granted October 1, 1964 to October 1, 1965, for a total of | 19,700.00 |
| Total | 40 | $31,000.00 |

The committee is experiencing collection difficulties with some of the former students who received loans under the plan instituted by the House of Delegates in October, 1955, and discontinued when the agreement was made for the Indiana National Bank to assume the responsibility of making and collecting the loans. Mr. Hollowell, attorney for the association and secretary of this committee, has devoted much time to this problem and, as a result, arrangements have been made with six of these delinquents for repayment. Three loanees have not responded in any way to any of the committee's letters regarding repayment, and therefore, the committee has authorized Mr. Hollowell to proceed as is necessary in order to collect these accounts.

A report on the Student Loan fund under association management from October, 1955, to July 31, 1963, follows:

| | |
|---|---|
| Total loaned to 117 students | $58,458.36 |
| Total repaid by loanees as of July 31, 1965 | 38,829.33 |
| Total amount outstanding, July 31, 1965 | $19,629.03 |

Of the 117 who received loans —
- 64 have repaid in full
- * 31 are making payments
- * 10 have made no payments
- * 6 are in internships — repayment not due until July, 1966
- * 6 are still in school — repayment not due until July, 1967

* The above mentioned 53 loans still outstanding total $19,629.03.

The financial status of the Student Loan fund for ten months of the fiscal year 1964-65 is shown by the following report:

| | |
|---|---|
| Cash on hand, October 1, 1964 | $12,925.46 |
| *Receipts:* | |
| Repayments on loans, 10/1/64 thru 7/31/65 | 7,078.34 |
| Interest earned on loans | 507.92 |
| Donations | 1,000.00 |
| Total receipts | $21,511.72 |
| *Expenditures:* | |
| Investments — short term bills | $18,564.69 |
| Cash on hand as of July 31, 1965 | $ 2,947.03 |

LESTER D. BIBLER, M.D., *Chairman*
JAMES O. RITCHEY, M.D.
JOE M. BLACK, M.D.
OTTIS N. OLVEY, M.D.
GLENN W. IRWIN, JR., M.D.
EUGENE S. RIFNER, M.D.
ROBERT HOLLOWELL, *Attorney*

## Building Committee

The report for the operation of your headquarters building for the period beginning June, 1964 through May of 1965 is as follows: The total cost for utilities, supplies and janitorial service for the year totaled $11,943.21. On this basis it makes our cost per square foot per year come to .905. Depreciation on the building adds another $5,870.30; insurance $756.25; making a total which could be charged amounting to $18,569.76. If we add in the cost of depreciation and insurance, our building is costing us $1.408 per square foot per year to main-

tain our operation.

We remind you again that this is considerably less than rental space would cost your association for the equivalent space we have here. Your committee, with the assistance of the Executive Committee, since moving into the building in May of 1962, has been able to reduce the indebtedness on the building from $85,000 to $36,000. Interest on the borrowed money for the past year amounted to $2,373.09, which averages out to $197.76 per month.

The area in which our building is located continues to grow and many additional offices and apartment buildings have been constructed or are in the process of being constructed. This, in our opinion, has greatly increased the value of our location and has placed us in the company of many other businesses, which shows the wisdom of the Council members in selecting this site several years ago.

The committee has two remaining projects, neither one of which has been completed. One is the authority by the House of Delegates for us to make an effort to obtain additional ground lying between our present location and Pennsylvania Street. Repeated attempts have been made to purchase this but as yet we have not been able to obtain an option or a proposed price for this property. This delay is no doubt going to be costly as additional buildings are being built in this area and no doubt the owners of this property are holding back for the time when they can obtain a premium for this ground.

The other project which has not been completed is the installation of a warming kitchen in the building. While contributions have been made, the amount for this purpose has been growing slowly and has not yet reached sufficient size to warrant this improvement.

The Building Committee has done its best to maintain the building in first-class condition and the time is coming in the not too distant future when redecorating and other upkeep investments will be necessary. We are hopeful, however, that we may retire the indebtedness on the building before any major operation in this line becomes necessary.

We are experiencing some growing pains, in fact the use of the basement has shown us that toilet facilities should have been placed in the basement and storage space is at a premium.

Your committee desires to express its appreciation to the members and officers of the association for their help and counsel and to the auxiliary for its contribution of $1,000.00 for adding table and chair equipment for the basement.

We understand the Iowa State Medical Society is now in the process of building its new building, which is largely copied from our building and we think this bespeaks well for the design and facilities of our headquarters office.

We would hope that those of you who have not as yet visited the building will take the opportunity to do so while attending this convention.

RALPH V. EVERLY, M.D., *Chairman*
FREDERIC W. BROWN, M.D.
R. CASE HAMMOND, M.D.
JACK E. SHIELDS, M.D.

# Reports of Commissions

## Constitution and Bylaws

The Commission on Constitution and Bylaws has had several matters referred to it for consideration and make the following recommendations for changes in the Bylaws:

*"Chapter VIII, Sec. 1 be amended as follows*: By adding after the line "The Medical-Legal Review Committee" and before the "Commission on Convention Arrangements"—*The Future Planning Committee.*

*Chapter XIV of the Bylaws should be as follows*: "Future Planning Committee. Section 1. The Future Planning Committee shall consist of nine members to be appointed by the President for terms of three years. Terms shall be staggered so that three members' terms expire each year; at the first, three members shall be appointed for one year, three for two years and three for three years. Thereafter all appointments shall be for a period of three years. The President, President-elect, Chairman of the Council, Chairman of the Executive Committee and Editor of *The Journal* shall be ex-officio members. The membership should be varied, according to experience, age, size of local county medical society and geographical area. At least one-third to one-half should be in the age group who would be in practice in the future contemplated, that is ten to twenty years distant.

Sec. 2. The function of this committee shall be to study and anticipate future trends and to stimulate the various commissions in coordinated directions so there is concord to the entire operation of Indiana State Medical Association. It is not contemplated that it be an operational committee." Present chapter XIV be re-numbered chapter XV and all other chapters re-numbered in the appropriate numerical order.

*Chapter XXVII, Sec. 2 of the Bylaws be amended as follows*: "Ninth District" shall be amended to read as follows: "Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton, White and *Newton* Counties." "Tenth District" shall be amended by deleting the word "Newton," which would then make it read as follows: "Tenth District—Jasper, Porter and Lake Counties."

The commission had before it a recommendation by the President that an oath of office be administered to incoming officers of the association. Your commission wholeheartedly agrees with this recommendation, feeling it would give more dignity to the office of president, president-elect, treasurer and councilors.

We, therefore, recommend that *Chapter V of the Bylaws be amended by adding a* new Section 5 to read as follows: "Section 5. The officers of the Association shall be installed by taking the following oath of office: I, _____, solemnly swear that I shall carry out to the best of my ability, the duties of the office of the Indiana State Medical Association to which I have been elected.

I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to do the task of bringing increasingly improved medical care within the reach of every citizen.

I shall uphold the Constitution of the United States of America and of the State of Indiana, the Constitution and Bylaws of the American Medical Association and the Constitution and Bylaws of the Indiana State Medical Association at all times.

I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations, I pledge myself, so help me God."

*Provisional Two-Year Membership*: The commission also had before it a proposal of a two-year provisional membership being instituted and this has been discussed repeatedly at each meeting. It was felt by your commission that this matter merited further study and therefore, the commission has appointed a sub-committee from the commission to study this proposal and we hope to be able to report our findings at the 1966 meeting.

*Grievance Committee*: Also your commission had before it the recommendation of the President last year that the name of the Grievance Committee be changed. This proposal was discussed and the general consensus of the commission members was that the name of the Grievance Committee should not be changed.

*Amendments to the Constitution*: The Commission on Constitution and Bylaws recommends the following changes in the Constitution of the association: (It is to be understood that this portion of the report will have to lay over for final adoption at the 1966 session of the House of Delegates, but in accordance with the Constitution and Bylaws are being presented at this time).

Delete #3 under Article IX, Sec. 5, which reads as follows: "The alternate Councilor shall not have the power of discussion if the regularly elected Councilor is present."

*Article V*—We recommend that Article V be amended by adding: after the word, "Delegates" and before the word, "elected" the following: "or their designated alternates", making this read, "(1) Delegates, *or their designated alternates,* elected by the component county societies"; and (2) be amended by adding after the word "Councilors" the following: "or their designated alternates" making it read "(2) the Councilors, *or their designated alternates.*"

*Article VI*—The first line be amended to read as follows: "The Council shall consist of (1) the Councilors *with power to vote, and their duly elected alternates, without power to vote, except in the absence of his Councilor*". This will then make Article VI read as follows: "The Council shall con-

sist of (1) the Councilors *with power to vote and their duly elected alternates, each of the latter without power to vote, except in the absence of his Councilor; and* (2) *ex officio the President.* . . .
GORDON S. FESSLER, M.D., *Chairman*
THOMAS H. GOOTEE, M.D., *Vice-Chairman*
RICHARD L. GLENDENING, M.D., *Secretary*
GEORGE W. WILLISON, M.D.
JAMES N. TOPOLGUS, M.D.
MAURICE E. GLOCK, M.D.
BURTON KINTNER, M.D.
A. W. CAVINS, M.D.
HOWARD E. SWEET, M.D.
JOSEPH F. FERRARA, M.D.
B. D. WAGONER, M.D.
CHESTER L. WAITS, M.D.
JACK E. DITTMER, M.D.

## Legislation

All years are busy ones for the Legislative Commission, but this one was even more so because of the meeting of the Indiana General Assembly, January to March, 1965, and the increasing pressure of the now familiar government proposals for "Fedicare." At the time of writing this report, the final outcome is in doubt primarily as to the details of how much federalization of medicine will occur. The "Mills Bill HR-6675" became a three-layer cake with frosting as the Administration utilized its control of Congress to bring about this far-reaching, first step to total socialization of medicine. Representatives of your Legislative Commission, along with members of your Executive Committee, held the annual dinner in Washington, D. C. in March with the Indiana Congressional Delegation and their staffs as our guests. This dinner was held earlier than usual in an effort to do all possible to defeat Medicare. Our efforts must be long-range, not just this year. We need the best possible relationship with all the Congressmen and Senators, because there are many medical issues and we do want to represent you as best possible on these issues.

In late May, your chairman and co-chairman returned to Washington for the annual workshop of AMPAC. This was a stimulating and practical meeting, as we learned more of the art of politics, a very necessary point for any legislative group.

The early part of the year was filled with meetings in conjunction with the meeting of our State Legislature. The members of the commission labored long and faithfully, reviewing the many bills, 125 estimated, having significance for the members of ISMA. We are happy to report a successful session in spite of the radically different make-up of the General Assembly. Not only did the majority of the bills actively sponsored by ISMA pass, but improved our "image" by having some positive suggestions and support for progressive health legislation. Only once was it necessary to "call out the troops" through telephoning many of you to talk personally to legislators on an issue. This was to defeat the poorly written Psychology Licensing Bill. Your response impressed not only the legislators, but other interested legislative spectators.

As in the past, the membership of ISMA, and especially the legislative commission, are in debt to a few special people. I refer to Senator James Kirtley, M.D., who had the brunt of the load due to his membership in the majority party, to Representative Otis Bowen, who in spite of few troops, conducted himself ably as the minority party leader, and to the "pros" of our staff, Jim Waggener, Howard Grindstaff and Bob Amick, along with Ken Bush and the ISMA office staff. Last, but by no means least, our thanks to the auxiliary for its continued fine supporting role; future prospects are for an even more successful association with our ladies in legislative affairs.

The Commission on Legislation suggests and requests the Council to authorize the president of the Indiana State Medical Association, or individuals selected by him to:

(I) Formulate and send letters to the Indiana Congressional Delegation, pointing out the many dangers and potential pitfalls in S. 596 or H.R. 3140, and suggesting positive ideas whereby the bill would support and strengthen present patterns of patient care and doctor-patient relationships while bringing about further progress in medical education and research.

(II). That the president or others selected, at the earliest possible time hold discussions with:

(1). The Dean of Indiana University Medical School;

(2). Representatives of:
- a. The Indiana Chapter of AAGP
- b. The Indiana Chapter of ASIM (American Society of Internal Medicine)
- c. ISMA Commission on Aging
- d. ISMA Commission on Medical Economics
- e. ISMA Commission on Medical Education

(3). Mr. Frank Woolley, or other AMA representatives to learn detailed plans of AMA re. S. 596.

(4). Representatives of any other group deemed to have interest in and to be of possible help in this type program—e.g. S. 596.

(III). That following such discussions, any further ideas relative to amending or revising the present bills be forwarded to our Congressmen and to AMA spokesmen.

(IV). Further that from the discussions, a semi-permanent group be formed to develop policies and plans for implementing in Indiana whatever bill is finally passed.

In conclusion, let me point out that this report of the year's activity should be a reminder of the many things that must be done every year if we are to maintain our position of capable and responsible leadership in the struggle for better health for all the people of Indiana. Your help in deciding the issues and then backing up your commission in the goals is paramount. I hope that every member of ISMA will be an active legislative member; this means participation in I-HOPE. Have YOU joined for this year?

Finally, I wish to thank all of the members of the commission, the officers and members of ISMA for their great help in making this a successful year in spite of the odds.

DWIGHT W. SCHUSTER, M.D., *Chairman*
EUGENE F. SENSENY, M.D., *Vice-Chairman*
JACK W. HICKMAN, M.D., *Secretary*
DANIEL M. HARE, M.D.
HAROLD MANIFOLD, M.D.
DON KERR, M.D.
LESLIE M. BAKER, M.D.
JOSEPH G. S. WEBER, M.D.
JOHN DAVIS, M.D.
PAUL T. LAMEY, M.D.
JAMES CRAIN, M.D.
PHILIP ROSENBLOOM, M.D.
DONALD K. WINTER, M.D.
OTIS R. BOWEN, M.D.
DON E. WOOD, M.D.
DONALD R. TAYLOR, M.D.
JAMES M. KIRTLEY, M.D.

## Public Information

At the time of the writing of this report, the Commission on Public Information had met twice during the year, and was planning a third meeting on July 18, 1965, to conclude the business of the commission for the year. During the year the commission continued with several projects which are listed below with an explanation of action and the status of certain of these projects:

1. *Television series, "Doctors at Work."* The commission, upon the approval of the Executive Committee of the association and working in cooperation with Merck, Sharp and Dohme regarding financial assistance in utilization of this series, circulated a memorandum to the component county medical societies in April asking those societies who would be interested in doing a TV series, locally, to contact the headquarters office. The tentative plan for use of these programs involved their use in October or early November, 1965. Officials of Merck, Sharp and Dohme pointed out that they would provide adequate funds to lease these shows if there could be good television coverage and active participation by county medical societies. As of this writing, three county medical societies have expressed interest and have previewed films. These include Vigo, Allen and Delaware-Blackford County Medical Societies. Further steps are at the present being planned to augment interest and use of this public service series.

2. *Medical Self-Help Series.* The Medical Self-Help series of films have been partially completed through the filming of an opening dramatization and an introductory opening and closing by Dr. Joe Black, president of the association. At present, the Medical Self-Help films are being further prepared through the use of additional filming of opening and closing material to establish closer identity to the Indiana State Medical Association. Two TV stations in Indianapolis have been approached on utilizing the Medical Self-Help Series, which, of course, would be a TV classroom approach to teaching medical self-help in emergency situations, but as yet there have been no positive commitments by these stations. However, the commission feels that a continuation of effort should be made to utilize TV and where possible, medical societies and medical auxiliaries should use the films in setting up Medical Self-Help programs locally with community and civic groups. As soon as the films are complete, the commission plans to advise county medical societies of their availability.

3. *Speakers Bureau.* The Public Information Commission also gave consideration to the establishment of a state-wide speakers bureau, but expressed the feeling that this should be a local medical society responsibility and recommended that when requests for speakers in a specific county are made to the headquarters office, that the request be referred to the county medical society wherein the request originated. The headquarters office, of course, can supply to speakers, in most instances, information on a great variety of subjects from legislation to medical education since this information is contained in kits, literature and prepared speeches.

4. *Waiting Room Literature.* The Public Information Commission also recommends that popular magazine publications be replaced in doctor's waiting rooms by publications which deal with the medical point of view on political issues, health problems, world events, and so on. The commission feels that it is here that the physician can exercise a great deal of influence on public thinking, and doctors should utilize their waiting rooms as a vital adjunct to improving public understanding of the professions' collective point of view.

5. *Journalism Awards.* The commission, also, during the year, followed through with the medical journalism awards program, as recommended by the commission and adopted by the 1964 House of Delegates. Announcements and applications were sent to all newspapers in the state and to all county societies concerning the awards which will be given at this annual convention of the medical association, should a meritorious recipient or recipients be selected. The commission received five applications for awards, which were to be reviewed at the July 18 meeting of the commission.

6. *Information Service.* During the year, too, the headquarters office continued to act as a source of information, providing health literature, legislative leaflets, films, tape recordings and so on, to physician members, the general public and to students. The headquarters is finding that more requests, annually, are being directed to the medical association for this type of material,—necessitating an increasing demand on the headquarters to maintain larger supplies of materials.

7. *State Fair Exhibit.* As a part of the Public Information Commission's continuing effort to work in areas of public education concerning matters of health, the Indiana State Fair exhibit this year was entitled "Life Begins." The exhibit was designed to present to the public a basic concept of the anatomy associated with conception

and birth. The initial portion of the exhibit depicted cell division. The next portion dealt with the growth of the fetus on the wall of the uterus through the eighth week and the remaining portions of the exhibit were actual human babies developing to full term. The association has found that this has been one of the American Medical Association's most informative and well attended displays. Throughout the years the exhibit has been periodically displayed. The exhibit was, as usual, displayed in the Board of Health Building at the Fairgrounds where literature was distributed. Members of the Woman's Auxiliary were in attendance along with Indiana University Medical School seniors who took blood pressures.

8. *Emergency Medical Identification.* During the past year, too, the Public Information Commission continued to distribute widely the Emergency Medical Identification cards with the suggestion that those who felt the need for utilizing the card obtain, for themselves, the emergency medical signal device which can be purchased at a number of jewelry stores throughout the state. This program was initiated in the spring of 1964 when an article was published in *The Indianapolis Star Magazine.* The story was written by Mr. Joe K. Shepard of *The Star* staff. Since that time the association has distributed several thousand of the identification cards and requests continue. The commission plans continuing publicity on this public service program.

9. *Other Publicity Activities.* Part of the Public Information Commission's responsibility is to publicize activities which are being participated in by other commissions. This year, a feature story was written on the preceptor program and was given to *The Indianapolis Times* where it was published. Additional internal publicity on this program was promoted through the *ISMA Journal* and exhibits at ISMA and IAGP conventions.

Also publicized during the year were the Junior-Senior Day program, a project of the Commission on Public Health, and the exceptionally outstanding program of the Decatur County Medical Society in the area of Community Health Week. This county society's "Health Week" program received attention in *The Greensburg News,* in the Indiana State Medical Association *Journal* and through the American Medical Association's national publication *PR Doctor.* The Decatur County physicians received unusual acclaim in this publication for their effort. As always, too, the Public Information Commission is responsible for circulating stories on the annual convention to its members and the public. A press room was set up at the annual convention where reporters from the press services, Indianapolis dailies and Indianapolis television and radio stations had, at their fingertips, facilities for reporting to the public the scientific proceedings, the House of Delegates meetings and other events of the association.

10. *Press Relations.* Also as directed by the Public Information Commission, the headquarters office continues to provide to the press and broadcasting media, appropriate background information on all matters pertaining to all medical association programming, projects, viewpoints and philosophies.

Headquarters office continued to provide students with background information and details on health, legislation and education for use in their classes. It has also provided many of its physician members with appropriate kits of materials for speeches in various areas of public enlightenment, most predominantly in the areas of medicine as a career and in legislation.

HARRY G. BECKER, M.D., *Chairman*
STUART R. COMBS, M.D., *Vice-Chairman*
GLEN McCLURE, M.D., *Secretary*
L. EDWARD GAUL, M.D.
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RICHARD W. HOLDEMAN, M.D.
WILLIAM G. MOORE, M.D.
OTTIS N. OLVEY, M.D.

## Governmental Medical Services

1. *Disaster Preparedness*

Dr. Charles R. Alvey, chairman of the Commission on Governmental Medical Services, represented the Indiana State Medical Association at the American Medical Association's Disaster Preparedness Meeting in Chicago during the year. Emphasis here was placed on the need for pre-planning and continued disaster preparedness drills.

The committee made additional plans for the utilization of the Medical Self-Help film series. A follow-up contact was made with Mrs. A. L. Marshall, chairman of the Committee on Civil Defense for the Woman's Auxiliary of the Indiana State Medical Association, to discuss with her the possibility of auxiliary cooperation in this program of utilization of the Medical Self-Help series. Mrs. Marshall said that the auxiliary would be happy to assist.

Effort has been made during the year to place the Medical Self-Help series on a public service time basis with two Indianapolis television stations, but this has been unsuccessful. The films themselves are in the process now of being altered with a new refilming of an opening and closing segment of the film to more closely identify them with the Indiana State Medical Association.

Once this process is completed, the films will be ready for utilization by county medical societies. Contact is being maintained with the Indiana State Board of Health Division of Civil Defense and they have stated that they will cooperate in every way possible to assist in utilization of these films. Several booklets, pamphlets and brochures are available for use with these films. As soon as the films are complete, county medical societies

will be advised and will have an opportunity to utilize these films in local programming before women's clubs, youth groups, local civic groups and others.

2. *Liaison on Veterans Affairs*

The Commission on Governmental Medical Services has remained active in this area and during the year hosted the Wednesday, May 5, meeting of the group, which is made up of representatives of the Indiana State Medical Association, Indiana Hospital Association, Indiana State Dental Association, Indiana Department of American Legion and the Indiana Pharmaceutical Association.

This meeting constituted the 48th meeting of this liaison group. The main speaker for the occasion was Mr. Frank Woolley, field representative for the American Medical Association, who talked at length on H.R. 6675 as it affected veterans and the public at large. It was an extremely informative discussion and many questions were asked. The liaison group, of course, continues to be a "sounding board" for many programs which are of mutual interest to the organizations involved.

3. *Legislative Follow-up to Recommendation Concerning a Medical Director for the Department of Correction*

As a result of the Commission on Governmental Medical Services study of conditions in the various penal institutions in Indiana, Senate Bill 325 was introduced in the state legislature which would have created a division of medical care and treatment in the Department of Correction. The bill passed by a large majority but the Governor vetoed the bill.

4. *Hospital Disaster Plan Guide*

This guide entitled, "A Guide to Hospital Disaster Planning" was prepared by the Indiana State Board of Health in cooperation with the Indiana Hospital Association and the Indiana State Medical Association. "The purpose of the guide is to aid hospitals in preparing and updating their disaster plans to meet the present licensure requirements on disaster planning and in no way is it intended for it to have regulatory status." This is the opening commentary on the guide by Dr. A. C. Offutt, State Health Commissioner. The Commission on Governmental Medical Services reviewed the guide, approved it and recommended its approval to the Executive Committee of the Indiana State Medical Association. The guide is 70 pages in length and covers every possible area of hospital programming under disaster conditions.

5. *Mental Health*

Planning for mental health by numerous Task Forces appointed under the Commission for Mental Health for the state of Indiana has continued for the second year as it has in all other states of the Union.

The original grant under which planning for mental health has been operating was terminated July 1, 1965. However, it is anticipated that the Task Forces will be continued in some manner so that their experience and knowledge gained in this survey and drafting of plans for the future may be utilized in implementing these plans. Because of the time consumed in organizing these Task Forces, many of the final drafts of the individual Task Forces have not yet been formalized.

The individual Task Force's surveys include need for psychiatrists, psychiatric social workers, clinical psychologists, attendants; the codification of existing laws pertaining to mental illness and mental health; the need for additional physicians and the correlation for additional training facilities for medical students in Indiana; as well as the need for mental health clinics and/or expanded treatment facilities in general hospitals for mentally ill patients and the future role of existing state mental health hospitals. Studies were also made of the treatment needs of mentally retarded children.

The Council of the American Psychiatric Association, at its meeting in December, 1964, decided from their survey of many state plans that a bold enough approach was not being incorporated in many of the plans and cited the following deficiencies: (a) The rejecting attitudes of the public (and of professions) will impede efforts to treat seriously ill persons living in the community; for all that has been done to further acceptance of the mentally ill, enormous improvement, especially through structured programs of public education, is still needed; (b) Continuity of care, as approached in various plans, seems to constitute more an ideal acknowledged to be desirable than a goal intended to be accomplished; (c) Procedures for collaboration among states to provide service in metropolitan areas that spread across state lines are not well developed; (d) In many cases where individual components of comprehensive service will be provided by separate agencies, the means of effecting coordination and delineating ultimate responsibility are often more implicit than explicit, and the tough question of who will surrender prerogatives and autonomy, and to whom, is often ignored.

Therefore, a conference to be attended by committees from the planning commissions of the several states was arranged in Washington, D. C., on February 19-20, 1965. This conference was addressed not only by outstanding planners themselves but also from such major social forces as religion and organized labor for all disciplines within and related to the mental health field. The group of speaker and panelists was of rare distinction.

Dr. Donovan Ward, president of the American Medical Association, addressed the conference and summation of his address follows: He discussed the opposition in 1964 of the AMA's House of Delegates to the federal bill that would have provided funds for staffing community mental health centers. This action, he said, was not a "slap in the face to the mental health movement nor an attempt to sabotage a government program. Neither was it an action intended to deny governmental responsibility and participation in the mental health field." He quoted a 1963 statement of the House of Delegates indicating that "AMA supports multiple-source financing for community mental health

services and recognizes the need for additional expenditures, at all levels, in this area." The AMA is firmly committed, he said, to the proposition that the local community is most responsive to the health needs of its citizens and should assume the basic responsibility for these needs. "The next level is that of the state, and if its resources prove inadequate, then there is the federal government." If the present level of spending by communities for mental health indicates they are uninterested, "then let us abandon all pretense and give the federal and state governments full responsibility for the care and treatment of the mentally ill." If, however, this is not the case, "let both the public and private sector work together to assure our citizens that their mental health needs will be met on the same basis as their physical health needs." He urged the planners to make a particular effort to reach the county medical societies, "who represent the medical community closest to the people."

The Honorable Anthony J. Celebrezze, Secretary of Health, Education and Welfare, addressed the conference and the thesis of his talk was as follows: The wide array of services which you envision cannot be put into effect immediately in all communities. The first steps are to establish a nucleus of services and to formulate a plan to develop and expand these services. "We need more than buildings if we are to launch a new era in mental health care. Most communities have found that the need for services and for skilled people to provide these services, is fully as great as the need for facilities. The cost of mental illness will be largely a public responsibility, at least for the immediate future. Those who need care the most are children, the aged and patients from low-income families. It is important, therefore, that all levels of government contribute funds and resources for the operation of community health services. We must not lose our momentum in this field."

Stanley F. Yolles, M.D., Director of the National Institute of Mental Health, made the following points: Probably our biggest problem, and the most difficult to solve, is that of planning mental health services for the socially deprived. This group of people, pushed and pulled by the stresses of chronic poverty, account for the highest rate of admission to state mental hospitals. And even though we cannot be sure that the components of poverty cause mental illness, we know that more culturally deprived persons go to mental hospitals because it is the only place to go.

At a legislative dinner during the conference, addresses were given by Congressman Oren Harris, chairman of the House Committee on Interstate and Foreign Commerce, Senators Lester Hill and Sam J. Ervin and Representative John E. Fogerty, of Rhode Island. Although they all talked of the need for improvement of mental health care throughout the nation, an animosity toward the medical profession, probably resulting from the timing and the current debates on Medicare in Congress, was quite apparent. This was particularly true in the case of Representative John E. Fogerty who was downright insulting to the medical profession.

Dr. Francis J. Braceland, past-president of the American Psychiatric Association, made the final summation in essence as follows: We may seem to be aspiring to be all things to all people. This is not so. Our mission is the prevention of illness, as well as the treatment of illness already manifest. Our main purpose is to draw together in unison, under one comprehensive plan, many disconnected and solitary efforts of many agencies, clinics, and groups now frequently duplicating one another's efforts and vying with each other for personnel and funds. In closing, Dr. Braceland proposed that it would be useful to establish a committee on the national level charged with three duties: First, to collect and examine carefully all information available on brief forms of therapy which can be used safely and effectively in community centers and elsewhere to return large numbers of persons quickly to their homes and jobs. Second, to examine in detail every possible method of educating the community in regard to emotional disorders and to remove as far as possible the stigma attached to them. Third, to suggest methods and design programs whereby psychiatric residents may be trained more broadly in community psychiatry.

Just before Dr. Braceland presented the concluding statement of the conference, Mr. Charles Frazier introduced to the delegates a resolution that would put the conference on record as supporting the enactment of federal legislation providing initial operating funds for community mental health centers. The text was as follows:

Be it resolved that this conference: (1) Seconds President Johnson's recommendation to the Congress that federal assistance be provided for the staffing of community mental health centers; (2) Endorses Senate Bill S. 513 and House of Representatives Bill H.R. 2985 to implement the President's recommendation, and (3) Urges that a coordinated and sustained effort be initiated by the American Psychiatric Association, aided by the National Association for Mental Health, and similarly dedicated groups and individuals, to develop a national consensus of support so as to make possible the achievement of our common national goal of adequate community mental health services for all citizens.

Mr. Frazier's motion was seconded by Dr. Harold Visotsky and by Mr. H. M. Forstenzer. A voice vote was taken. The motion carried with a single dissenting vote from the floor. Subsequently a delegate from Oregon submitted his dissent by mail.

This was the only vote taken on any issue during the meeting. There was little or no opportunity for discussion and many did not vote on the issue. I felt that many of the doctors in attendance were caught by surprise and, being guests of the American Psychiatric Association, refrained from voting on the resolution.

The Congress of the United States subsequent to this conference has passed House Bill 2985, a staffing bill authorizing federal funds to assist in

the initial staffing of community mental health centers. It provides 51 months of support, on a diminishing percentage, for each staffing project approved . . . 75% first 15 months, 60% next 12 months, 45% for the next 12 months and 30% for the final 12 months. The bill also authorizes an expenditure of $73,500,000 for fiscal years 1966, 1967, and 1968—plus an unspecified authorization of funds as may become necessary during the same period to provide for the continuation of staffing beyond the initial grant year.

No community mental health center has yet been started in Indiana, however, two are in a serious planning stage.

The American Medical Association held its 11th annual Mental Health Conference in Chicago on March 5-6, 1965. The theme of the meeting was insurance with regards to payment for hospitalization for mental illness. It was pointed out that most Blue Shield plans which are covering hospitalization for mental illness pay for a maximum limit of 21 days hospitalization. There were also statistical reports of surveys of noninsured mental illness treated in general and acute psychiatric hospitals which showed, in some 1,800 cases surveyed, the average hospitalization for an acute episode was 21 days.

The above presentations were for the purpose of comparison in a presentation by a representative of the United Automobile Worker's Union, giving details of their insurance coverage for mental illness, which was incorporated in their last contract with the automobile companies.

This phase of the contract calls for hospitalization for a maximum of 45 days for any acute mental illness and is supplemented by an additional allowance of $400 for follow-up and post-hospital treatment for mental illness. This insurance coverage, to be paid through national Blue Shield, is to be rated and planned for so that it can be put into effect within 18 months.

There were panel discussions which dealt primarily with the questions of what criterion indicates mental illness or emotional disturbance which requires hospital treatment; and what criterion indicates a "cure" or degree of improvement which indicates time for discharge of such a patient. There was no decision on either of these points and a criterion is yet to be established.

There were papers and panel discussions on comprehensive planning for mental health from various national authorities and state representatives dealing with their experience and progress in mental health planning under federal grants for the last two years, reporting on the number of federally financed community mental health clinics which, as a result of comprehensive planning, are to be established in several states. Some states have as many as seven clinics, either approved or being built. The first one to be opened under Kennedy's Mental Health Bill was opened in Chicago in March, 1965.

There was some discussion of the fact that appropriations to aid in the payment for staffing of mental health clinics was left out of the Kennedy Mental Health and Mental Retardation Center Bills due to the stand of the American Medical Association opposing federal payment for staffing. In discussion it was pointed out that mental illness has a marked predilection for the poorer segment of our population and therefore such clinics probably could not operate entirely on a fee for service basis. The opinion was also expressed that the general public is not now sufficiently aware and appreciative of the benefits to be derived from early intensive treatment in community mental health clinics so that they would support such clinics totally by local taxation.

The Council for Mental Illness and Health of the American Medical Association still believes and recommends that federal, state and local financing is necessary to underwrite staff salaries of community mental health clinics.

All members of the former joint steering committee, now designated as the Professional Advisory Committee for the State Commission on Mental Health Planning, are serving on the several mental health Task Forces.

The treatment center for mentally ill and mentally retarded children being built in Evansville is expected to be in operation within a year. Funds became available for appointing members for a staff July 1, 1965, however, no staff has yet been appointed. This is one of five combined hospital and outpatient treatment centers for children which are ultimately to be built in Indiana and which have been approved by the state legislature although no funds for additional building have been appropriated. These treatment centers are not mental health centers being developed under the federal community mental health program.

Our state mental institutions continue to have difficulty in hiring adequate numbers of psychiatrists and it is felt the Indiana State Medical Association should do everything possible to aid in securing qualified psychiatrists for these institutions.

The last state legislature appropriated only about 70% of the budget requested by the Commissioner of Mental Health for the next biennium. This will actually cause some curtailment of services previously rendered to the mentally ill in Indiana.

GLEN WARD LEE, M.D., *Chairman*
Committee on Mental Health,
Commission on Governmental Medical Services

6. *Veterans' Medical Care*

Last year we reported to you that as a result of our efforts, a revision of the fees for the care of veterans under the Home Town Care Program was undergoing revision.

Fifteen changes in the schedule were reported last year and through continued negotiations, which were originated by the Indiana State Medical Association several years ago, the V.A. has finally adopted a standardized nomenclature used by insurance firms and other governmental agencies.

Effective July 1, 1965, the Veterans' Administration adopted the California Relative Value Schedule, and inasmuch as Indiana does not have

a relative value schedule, it has been adopted by the administration for use in this state.

While experience is not sufficient to report at this time as to the results of this innovation, your commission will continue to watch the activities under this new arrangement.

7. *Welfare*

Your commission has been frequently requested to advise the State Department of Public Welfare on matters of fee schedules being requested by various county medical societies.

Inasmuch as your commission and the association have no factual knowledge of the various contractual arrangements between the county department of welfare and the county medical societies, we sought permission from the Council to make a survey of the counties in order that we might be in a better position to answer the requests of the state department. Permission was granted and we report herewith the information we have gleaned from the counties who have reported.

July 16, 1965

**Report of Study of County Welfare Schedules**

The attached is a brief summary from counties who reported their schedules for welfare programs.

The first column indicates the year the county's schedule was last revised. Column two is the name of the county and column three denotes their surgical schedule. The keys are as follows:

"S" Standard Blue Shield schedule
"I" Intermediate Blue Shield schedule
"P" Preferred Blue Shield schedule
"VA" Veteran's schedule
"Other" Did not indicate

The next column lists the fee the doctor receives for an office call. In many of the counties this fee also includes medication.

The next column indicates the fee the doctor receives for a house call during daytime hours. The next column indicates the night rate. In most instances, mileage at the rate of 50c per mile one way is payable in addition to house call fees for rural calls. In some instances this also includes medication.

The next column indicates a fee a doctor receives for a hospital call and the final column indicates the percentage below the usual and customary fee charged in the respective county.

In Huntington County, you will note the doctor reports an office call fee of $3.00. The welfare contract shows payment to chiropractors for office calls @ $3.00 and osteopaths @ $4.00.

Many of the reports list complete schedules for x-ray, pathologists, hospitals, etc.

Time did not allow a complete compilation of all information for this report but this will give you some idea of the arrangements now in effect in the counties who have answered the questionnaire, and as reported by them.

| Year | County | Surgical Schedule | Office Call | Day Home Call | Night Home Call | Hospital Call | Percentage Below Usual Fee |
|---|---|---|---|---|---|---|---|
| 1965 | Bartholomew | S | $3.00 | $5.00 | $ 7.00 | $10.00 - 3.00 | — |
| 1965 | Boone | I | 3.00 | 4.00 | | | 10 - 20% |
| 1963 | Clay | S | 3.00 | 6.00 | 8.00-10.00 | 10.00 - 3.00 | 30 - 40 |
| 1962 | Dearborn-Ohio | S | 4.00 | 5.00 | 5.00 | 3.00 | 10 |
| 1964 | Decatur | I | 3.00 | 5.00 | 5.00 | — | 25 |
| 1955 | De Kalb | Other | 2.00 | 3.00 | 3.00 | 10.00 - 3.00 | — |
| 1963 | Delaware | S | 4.00 | 6.00 | 6.00 | — | — |
| 1946 | Fayette | P | 4.00 | 6.00 | 10.00 | 15.00 - 5.00-4.00 - 3.00 | 10 |
| 1964 | Floyd | P | 4.00 | 5.00 | — | — | Same |
| 1960 | Fountain-Warren | S | 3.00 | 5.00 | 8.00 | 10.00 - 3.00 | 25 - 50 |
| 1964 | Fulton | S | 3.00 | 5.00 | 6.00 | — | — |
| 1965 | Gibson | S | 4.00 | — | — | — | 20 |
| 1962 | Greene | S | 3.00 | 4.00 | — | — | 10 - 15 |
| — | Hamilton | — | — | — | — | 2.50 | — |
| — | Hancock | No schedule in existence - Welfare refused to implement | | | | | Kerr-Mills |
| 1965 | Harrison | S | 3.00 | 5.00 | 6.00 | 10.00 - 3.00 | — |
| 1965 | Henry | I | 4.00 | 6.00 | 6.00 | 15.00 - 4.00-3.00 | 20 |
| — | Howard | — | — | — | — | — | 50 |
| 1961 | Huntington (D.O. $4.00) (Chiro -$3.00) | S | 2.00 | 3.00 | 4.00 | 5.00 - 3.00-2.00 | — |
| 1957 | Johnson | S | — | — | — | — | 20 |
| 1965 | La Grange | I | 5.00 | 6.00 | 8.00-10.00 | 10.00 - 3.00 | Same |
| 1962 | Lake | S | 3.00 | 4.00 | 4.00 | 1.00 - 3.00 | 33⅓ |
| 1960 | Lawrence | S | — | — | — | — | 50 |
| — | Marion | G.H.P. Diem | 4.00 | 8.00 | 8.00 | — | — |

| Year | County | Surgical Schedule | Office Call | Day Home Call | Night Home Call | Hospital Call | Percentage Below Usual Fee |
|---|---|---|---|---|---|---|---|
| — | Marshall | S | 3.00 | 4.00 | 6.00 | 3.00 - 6.00 | — |
| 1964 | Montgomery | S | 3.00 | 4.00 | 4.00 | 3.00 | — |
| 1965 | Newton | V.A. | — | — | — | — | 30 - 50 |
| 1965 | Owen-Monroe | S. | 3.00 | 4.00 | 5.00 | — | — |
| 1965 | Parke-Vermillion | S | 2.00 | 3.00 | 4.00 | 3.00 | — |
| 1961 | Perry | Other | — | — | — | — | 33⅓ - 50 |
| 1959 | Pike | P | 3.50 | 4.50 | 6.50 | 1.50 - 2.00 | 25 |
| 1965 | Porter | I | — | — | — | — | — |
| 1960 | Posey | S | 2.00 | 4.00 | 5.00 | — | — |
| 1965 | Putnam | I | 3.00 | 4.00 | 6.00 | — | — |
| 1965 | Scott | S | — | — | — | — | — |
| 1965 | Starke | S | 3.00 | 4.00 | 5.00 | 3.00 - 5.00 | — |
| 1965 | Steuben | I | — | — | — | — | 50 - 75 |
| 1965 | Sullivan | S | — | — | — | 3.00 | 25 - 50 |
| 1964 | Tippecanoe | S & VA | — | — | — | — | 25 |
| 1965 | Vanderburgh | County Relative Value | 4.00 | 6.00 | 10.00 | — | — |
| 1962 | Wabash | S | 3.00 | 4.00 | 4.00 | — | 50 |
| — | Warrick | — | 2.50 | 5.00 | 7.00 | — | 50 |
| 1964 | Washington | Other | 3.00 | 5.00 | 7.00 | — | Same |
| 1964 | Wells | S | 3.00 | 4.00 | 4.00 | 2.00 | 20 - 40 |
| 1964 | Whitley | S | 3.00 | 4.00 | 6.00 | 10.00 - 3.00-2.00 | 15 - 25 |

This is only a progress report as the compilation of all the information is tedious and time-consuming and the above report to you indicates results in these areas in all counties up to the time of preparing this report.

We have been informed that some counties have endeavored to obtain the equivalent of Blue Shield preferred schedule for care under the Kerr-Mills Act in Indiana.

One county reported that the county director had told them the state department had received a report from the attorney general's office, pointing out that there should be only one schedule of fees for all programs under the state welfare department. The association obtained a copy of this report and has since filed a brief prepared by the association's legal counselor with the attorney general, taking disagreement with his report. As of the preparing of this report, a reply has not been had from the attorney general's office and chances are none will be received as the attorney general does not have the obligation of answering questions except those propounded by the various official departments of state government.

8. *Medicare*

For the contract year beginning April 1, 1963, ending March 31, 1964, the Medicare Department has handled a total of 10,241 claims; 5,149 were cleared for payment and these total $403,763.57. Eight-hundred-fifty-one of these claims were either returned for further information from the physician, rejected, or were still in the process of clearing for payment as of the above date.

9. *Planning Meeting in Office of Emergency Planning*

The commission wishes to thank Dr. Jerome Holman, Jr., of Indianapolis, for attending a planning meeting on health, in connection with emergency planning on June 24. Mr. Robert S. Bates, State Director of Emergency Planning, requested that a representative of the Indiana State Medical Association be in attendance.

CHARLES R. ALVEY, M.D., *Chairman*
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HERMAN ECHSNER, M.D., *Secretary*
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CHARLES HENDRIX, M.D.
DICK J. STEELE, M.D.
GLEN WARD LEE, M.D.
ROBERT P. SCOTT, M.D.
RAMON B. DUBOIS, M.D.
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ERNEST C. MURRAY, M.D.
GEORGE D. BUCKNER, M.D.
JAMES E. WENGER, M.D.
JEROME E. HOLMAN, JR., M.D.

## Public Health

During the past fiscal year of 1964-1965, the Commission on Public Health has held four formal meetings. The attendance and the interest of the membership has been excellent. The activity of the commission, however, has been in an ever-increasing broader range, working on the problems coming before it from various sources, especially references from the Council, concerns initiated by individual members, consideration of inquiries, re-

quests and recommendations from individuals and organizations, both lay and professional, reviewing of publications consistent with the commission's activities, liaison with the voluntary and governmental health agencies, especially the Tuberculosis Association and the State Board of Health, and attempting to send from its membership a delegate representing the commission to those meetings in which it seemed we should be represented.

Essentially the same committee structure has been maintained and an increasing number of ex-officio members have been brought into the commission when it seemed their assistance and consultation was desirable. These members have contributed greatly to the work of the commission and are hereby given grateful recognition. Committees have been frequently appointed and have worked well and the following standing committees have been maintained throughout the year.

Standing Committees:

*A. Committee on Industrial Medical Practices and Programs*:
Lowell W. Painter, M.D., *Chairman*
E. B. Haggard, M.D.
Daniel A. Gard, M.D.
L. W. Spolyar, M.D.
Sam Adair, M.D.
John P. Turner, M.D.
H. Glenn Gardiner, M.D.
Jacob Fleischer, M.D.
William Baughn, M.D.
E. S. Jones, M.D.

*B. Committee for Preventive Medicine and Liaison with State Board of Health*:
Gerald F. Kempf, M.D., *Chairman*
Arnold W. Brockmole, M.D.
John P. Turner, M.D.
Andrew C. Offutt, M.D.
Wilson L. Dalton, M.D.
Thomas O. Middleton, M.D.
Berniece M. Williams, M.D.
L. W. Spolyar, M.D.
Ralph Wilmore, M.D.

*C. Committee on Rural Health and Physician Placement*:
Forrest J. Babb, M.D., *Chairman*
T. Neal Petry, M.D.
Robert M. Seibel, M.D.
John Hickam, M.D.
Eugene S. Rifner, M.D. (*Consultant*)

*D. Committee on Traffic Safety*:
Thomas O. Middleton, M.D., *Chairman*
Andrew C. Offutt, M.D.
John P. Turner, M.D.

*E. Committee on Hearing and Vision*:
Berniece M. Williams, M.D., *Chairman*
Thomas O. Middleton, M.D.
Daniel A. Gard, M.D.
William Baughn, M.D.

### Report of Committee on Industrial Medical Practices and Programs

During the past year a variety of incidental questions, communications and publications have been referred to the Committee on Industrial Medical Practices and Programs. Particular effort has been made to continue with the project of gathering information and formulation of a report for the edification of members of the Indiana State Medical Association, entitled the "Principles of Industrial Practice in Indiana." It is hoped that this particular report as published herewith will be made available in brochure form for distribution by the Indiana State Medical Association through its members upon request, to physicians in other states and laymen or organizations where there seems to be a justifiable interest. Our sincere appreciation is here expressed to Dr. E. B. Haggard for his very extensive work in the preparation of this report, which is as follows:

### THE PRINCIPLES OF INDUSTRIAL PRACTICE IN INDIANA

**Issued by the Commission on Public Health of The Indiana State Medical Association**

#### FOREWORD

This is written primarily for the benefit of Indiana physicians who are *not doing* full-time industrial practice. The aim is to promote better understanding of the problems confronting all concerned, i.e. the employer, the patient, the insurance carrier and the physician, and as a result, to arrive at better patient care and at reduction of controversy.

Industrial practice differs from private practice in that the doctor quite often *should not* take the patient's story at face value, because the average worker is very prone to blame materials or conditions at work for many of his ailments. The doctor must take a careful history and carefully reason out the real cause of the patient's condition and report his facts and conclusions honestly. The doctor *must* be impartial. The patient's story (unless it is obviously consistent with his condition) should be checked by calling the employer. The first story the patient tells you is *most* important, and should be recorded in his own words. Also, when you treat an industrial case, many people are looking over your shoulder—the employer, the family of the worker, the union and the family doctor, and maybe an attorney—so you must be as accurate and as right as possible.

#### THE INDUSTRIAL BOARD
#### THE LAW
#### WORKMEN'S COMPENSATION AND OCCUPATIONAL DISEASES

The rock bottom foundation for handling industrial cases is an understanding of the law. Briefly stated, the Indiana law says: "There must be injury or death, by reason of an *accident or a disease*, that arises *out of and during the course of the employment.*" All conditions must be met. Injuries and diseases to which the general public is exposed are *not* covered. For instance: pneumonia causing work stoppage during the employee's working hours would not be covered because although the disease did arise *during* the

work, it did *not* arise specifically from the work or work condition (*out of the employment*). Similarly:—let us take a case of lumbosacral degeneration. This case is performing his regular work assignment and during this he performs a *normal* work movement and suffers back pain. In this case the condition arose during the work, *but there was no accident*, and therefore did not meet the requirements for compensability. Aggravation of pre-existing conditions by a bona fide accident are covered.

### CHOICE OF PHYSICIAN

Under the law the employer is responsible for furnishing the necessary medical attention for compensable conditions, and, by implication, *has the right to choose the physician* who will care for the case. Therefore, the physician must, if he already does not have it, obtain the employer's consent to treat the case. Otherwise the patient might not receive compensation and the doctor might *not be paid* by the workmen's compensation insurance carrier. Where the employer has a medical department with plant physician, the employee *must* report to the medical department for care. If he bypasses the medical department he usually would not be compensated and the doctor who actually did the care might not be paid by the workmen's compensation insurance carrier. Consent for employing a specialist or getting rehabilitation treatment (physiotherapy) should also be obtained when indicated. The patient, at all times, has the right to consult his family physician *at his own expense*. In an emergency, render the treatment first and then get consent to continue treatment.

### WILLFUL MISCONDUCT

Compensation is not allowed in cases where injury or death is due to the employee's intentionally self-inflicted injury or his intoxication, his commission of a felony or a misdemeanor, his willful failure or refusal to obey a reasonable written or printed rule of the employer which has been posted in a conspicuous position in the place of work, or his willful failure or refusal to perform any statutory duty. The burden of proof is on the defendant.

### INDEPENDENT EXAMINATION

The employer (or insurance carrier) has the right to obtain an independent medical examination or autopsy and the employee or survivors must comply.

### CONFIDENTIALITY

There is no such thing in workmen's compensation cases. The law states (Sec. 27, Workmen's Compensation Act) "*no fact* communicated to, or otherwise learned by any physician or surgeon who may have attended or examined the employee, or who may have been present at any examination *shall be privileged*, either in the hearing provided for in this act, or in any action at law brought to recover damages against any employer." The law actually requires *exchange* of medical information before any hearing before the Industrial Board.

### OCCUPATIONAL DISEASE

The definition of occupational disease by Indiana law, "OCCUPATIONAL DISEASES ACT OF INDIANA, Sec. 6 (a) is: 'A disease arising *out of and in the course of the employment.*'" (Note: both conditions must be present). "Ordinary diseases of life to which the public is exposed outside of the employment shall not be compensable except where such diseases follow as an incident of an occupational disease." This means that the physician, in a case of suspected occupational disease should first find out if the exposure is actually present at the patient's work. It is manifestly impossible for a person to have compensable silicosis if silica *is not present* at the patient's place of work. If silica is present, the patient must be shown to work in this exposure. Statistics show that the dermatoses are the most frequently diagnosed occupational diseases. Diagnosing a dermatosis as occupational should be done only after substantiation by patch tests or other appropriate measures *and by ruling out exposures* in hobbies, gardening, other work, cosmetics and clothing and by developing a history of recurrence of skin disease when the worker returns from vacation.

### CRITICISMS OF THE ATTENDING DOCTOR

The most frequent criticisms from employers, insurance carriers, regular plant physicians and attorneys are:

1. The attending physician does not use enough care at the initial visit to take a careful history and record it, preferably in the patient's own words, and along with the physical findings to arrive at an opinion as to whether or not the medical condition is really due to the work as defined by law. Too often, the attending physician jumps to a conclusion that the condition is due to the work, whereas the condition might be due to the activity of the patient outside of the plant or the condition does not fulfill all the conditions of the law.
2. The physician does not submit a written report promptly and/or does not fully report all the pertinent facts.
3. The employee is sent back to work too soon or too late.
4. Estimations of permanent impairment are too far out of line to be realistic.
5. Permission to treat the patient is not obtained from the employer at the initial visit and permission to employ a specialist or to use rehabilitation measures (usually physiotherapy) is not obtained before these are done.
6. The imposition of unrealistic restrictions when the patient is allowed to return to work. Consult with the employer on this.
7. The physician reports to the company regarding a medical condition or disability

when, in fact, the physician has not treated the patient during the period alleged by the patient. In other words, certifying (on the patient's story alone) that a period of disability has existed.

8. Not using, or delaying the use of, a specialist in cases where good medicine demands the *best* of care. This includes the use of rehabilitation treatment such as physiotherapy.
9. Requesting medical leave out of all proportion to the severity of the illness.
10. Excessive charges for treatment or reports.

### RESPONSIBILITIES OF THE ATTENDING PHYSICIAN

1. Take a careful history at the initial visit, preferably in the patient's own words, to determine if the condition comes under workmen's compensation provisions. This should include the "how, when and where" and the patient should be questioned until the physician can get a clear picture of what really happened. In the event of suspected occupational disease, establish the nature and duration of the exposure.
2. Get the employers consent to treat the case whenever this is necessary, and his consent to use a specialist or rehabilitation treatment when such is needed.
3. Report the initial visit *promptly* and fully to the employer or insurance carrier, giving all the pertinent facts along with an opinion regarding how long the employee will be off work and as to whether or not any *permanent impairment* is expected and an *estimate* of the amount of permanent impairment expected. Actual evaluation of permanent impairment should await until the patient has achieved all benefits from treatment and rehabilitation and the condition has become static. *Promptness* of reporting is *essential.* All actions in the case are based on the reports. Also, if you do not report promptly the patient will not get paid on time. Progress reports should be sent out about every 30 days on long cases.
4. Know, or find out about, the materials and working conditions in the plant.
5. Since the physician's first concern is the welfare of the patient, he is obliged to see that the patient gets the *best* of care. This means the employment of the specialist at the earliest moment indicated. Patients, employers and insurance carriers will not object to this, since they are vitally interested in the best possible end result and the return to work as soon as the patient can render useful and productive work. Injuries to eyes, hand tendons and fractures are examples of injuries that quite often need early employment of the specialist. The physician should strive for the best possible result in the shortest reasonable time. Rehabilitation treatment such as physiotherapy should be used when indicated. Be sure to get consent from the insurance carrier *before* employing a specialist or ordering rehabilitation therapy.
6. Fees—it appears that a fee schedule for industrial injuries has not been established in Indiana. The following general principle should not meet with any substantial objection from employers or insurance carriers—charge the fee that you would ordinarily charge the private patient in the same income class. Avoid excessive charges for treatment or reports.
7. Keep careful and accurate records, and be prepared to appear before the Industrial Board and substantiate *anything* you might report about the case. Be prepared with history, clinical and laboratory findings, treatment and response, measurement of any final impairment and with a realistic estimate of the percentage of any permanent impairment.
8. The *final* decision regarding impairment is a *legal* decision and the physician is *not* expected to render the *final* decision, but he is expected to give all the pertinent facts and findings so that a final decision can be reached by those responsible (the Industrial Board). He is expected to give his estimate of permanent impairment.
9. The Internal Revenue Service requires the insurance carrier to get the doctor's Internal Revenue service number before doctor bills are paid. The doctor should comply with the insurance carrier's request for this information.

### SENDING THE PATIENT BACK TO WORK

This applies to absences from work due to industrial and non-industrial illness or injury.

1. *Non-industrial cases*: Consult with the plant doctor or management and describe the medical condition and its progress and tell what the patient can now do. The plant will tell you if they can use the employee at all and will be willing to describe jobs available in the plant. Many plants can use the employee in work lighter than his usual for a limited, or even permanent, period of time. *Communicate.* Any work restrictions you might wish to impose should have a definite time limit attached—either temporary or permanent and these restrictions should be *realistic.* Allow the patient to return to work only when he can render useful, productive service. Of course many minor conditions can return to work after receiving first aid or after a short period of time and treatment.

2. *Industrial cases*: Here some plants will permit return to work before full recovery, provided that the employee can render productive work. Some others will demand full ability to work. Again—talk to the employer and discuss the problem.

3. *Work restrictions*: In this area don't be vague and general—spell it out, i.e.—this patient can lift up to X pounds and can or cannot be on his feet

eight hours a day, can bend, stoop and lift without restriction or with whatever restrictions you wish to see observed—and specify (realistically) how long these restrictions should be carried; this patient can, or cannot, climb stairs or ladders; can, or cannot, use hands fully or partially and describe any limitations of use. The terms "light" work and "sedentary" work mean many different things to various people. Sedentary work necessitates getting to and from work, some walking in the plant for the calls of nature and for lunch and maybe to get materials for the job. The employee cannot sit down all day. Consult with the plant and describe what the patient can do and by mutual agreement arrive at a decision as to whether or not the patient can return to work and under what conditions. Once more—restrictions should be realistic and have a specified time limit attached.

### PHYSICAL EXAMINATIONS

These are done for several purposes.

1. *Pre-employment examinations.* This should include a history about past illnesses, surgery, injuries and occupational exposures that might affect the work in prospect or affect the person's future health. The examination should include: height and weight, age, birthday, visual and hearing acuity, mouth, teeth and throat, chest, abdomen (especially for hernia), genitals, extremities and urine. If the history indicates, appropriate other laboratory work should be done. The purpose is to establish the patient's ability to work and to establish a health base line for future comparisons.

2. *The periodic examination.* In many plants this is done only on the executive people. Some others use it on all employees and some do not use it at all. At the examination the physician should advise the patient about correctible conditions found, and about health and work habits and urge him to seek any necessary medical care from his own physician. Any recommendations about continuance or change of work should be given to the plant management. Specific medical findings should *not* be reported to management.

3. *Return to work.* These are to assess the patient's ability to work and to give management information regarding any special placement problem. The doctor should report clearly what the patient can, or cannot do. You might need, sometimes, to call the worker's family doctor to get accurate medical background on the worker.

4. *Early retirement examinations (due to some degree of disability and not to age alone).* Here the physician should report the activities the patient cannot do. Then management will decide whether or not they have a job in the plant that the patient can do. If no such job is available, the employee will be given an early retirement. Industry will retire a worker whenever he can no longer render *useful productive service in the plant.* A good many of these people (who are retired) should be advised to apply for Social Security Disability, *but* the Social Security Disability program differs from industry in that it awards benefits *only* to those people who cannot render *any substantial* work *anywhere.* The Social Security report should include clinical and laboratory signs and findings *and especially* a careful description of what the patient can, or cannot, actually do. The clinical and laboratory findings should be included for the benefit of the reviewing doctors in the Social Security Disability program.

### WORK FITNESS CLASSIFICATION

The generally accepted classification of employees for work (and which is to be transmitted to the personnel department) is: A, B, C, or D, or 1, 2, 3 or 4. Class A or 1 means that the person is fit for any kind of work, Class B or 2 means that there are minor, but correctible, impairments which do not affect the person's ability to work. Class C or 3 means that there are impairments *not* correctible, which *do* affect the person's ability to work. These cases need a careful description of what they *can* do. Class D or 4 means that the person is *not* able to work in the plant at all, even with careful placement. Plants quite often set their own standards regarding the prospective employee. Some demand full, unrestricted ability to do *any* work in the plant. Some will consider hiring people with some handicaps. So you should know the standards of the plant you are examining for. At this point in time, most plants assume a heavy financial liability whenever they hire a worker. These liabilities are in the "fringe" benefit area—hospitalization insurance for employee and family, retirement benefits, health and accident benefits, benefits supplementary to workmen's compensation. Here, again, know the standards of the plant. A good pre-employment examination is a *must* as a base line.

### IN PLANT ACCIDENT PREVENTION, SAFETY AND HEALTH PROGRAMS

Here the industrial physician should first of all become familiar with the working conditions and the materials used in the plant, preferably by going on plant tours. Be alert to health and accident risks and recommend control of such conditions. Advise management of the risks and the need for control. In general the doctor is to act in an advisory manner to management, contributing his medical knowledge to any problems encountered. He should give health counseling to employees whenever it seems appropriate. By knowing plant conditions and materials, the doctor is in a much better position to handle the injuries and illness arising *out of the work* and *during the course of the work.*

### COMPENSATION FOR THE WORKER

The foundation of all payments to the worker is "THE AVERAGE WEEKLY WAGE." For injuries or illness arising before 1 April, 1965 the law considered the average weekly wage to be not more than $70.00 and not less than $30.00. For incidents or injury occurring on and after 1 April, 1965, the law says that the average weekly wage is

not more than $75.00 and not less than $30.00. Payment to the worker is 60% of the average weekly wage within the limits above. So the maximum payment was $42.00 and the minimum was $18.00 *before* 1 April, 1965. On and after 1 April, 1965 the maximum payment to the worker is $45.00 and the minimum is $18.00. Some companies will add a supplement to the compensation (out of their own pocket), and some will see that the worker gets his usual weekly wage. Payment is *not* made for the first seven days of disability, *unless* the disability lasts *more than* 28 days. If the latter occurs, then the worker is paid for the first seven days. In cases involving permanent impairment, the worker is paid for the weeks of lost time, but when the time comes for payment of the permanent impairment, payments *over and above* the first 26 weeks of disability *are deducted* from the final permanent impairment settlement.

### EVALUATION OF PERMANENT IMPAIRMENT

The following is a schedule of specific losses for which the payment to the worker is given in weeks of compensation. This is taken verbatim from the law and is binding and not subject to argument. In case the impairment does not specifically meet these listings, there is room for argument, but the physician should be realistic in his estimation of permanent impairment and not give an estimate that is far out of line. At an Industrial Board hearing, the out of line estimate could look silly in view of the opinions of other doctors, lawyers and claim adjusters, some of whom are bound to be present to testify. Some workers have grandiose notions about how much they are going to get in settlement of the claim. This schedule gives the facts, and the doctor can tell the patient about them, if he so desires.

### LISTINGS OF SPECIFIC LOSSES

Section 31, Indiana Workmen's Compensation Act, and Section 8 (d) 1 & 2, Indiana Workmen's Occupational Diseases Act, 1963 and including changes in the 1965 Act. In these listings complete loss of use of a part is equal to loss of that part by amputation.

For loss by amputation, or for complete loss of use of:

| | |
|---|---|
| Thumb | 60 weeks |
| Index (or first finger) | 40 weeks |
| Middle (or second finger) | 35 weeks |
| Ring (or third finger) | 30 weeks |
| Little (or fourth finger) | 20 weeks |
| Hand (or arm) ABOVE the elbow | 250 weeks |
| Hand (or arm) BELOW the elbow | 200 weeks |
| Big toe | 60 weeks |
| Second toe | 30 weeks |
| Third toe | 20 weeks |
| Fourth toe | 15 weeks |
| Fifth (little) toe | 10 weeks |
| Leg, ABOVE THE KNEE | 225 weeks |
| Leg, BELOW THE KNEE | 175 weeks |

Loss of *more than* one phalanx of thumb or of any toe equals the loss of the entire member (thumb or toe)

Loss of *more than* two phalanges of any finger (not including the thumb) equals the loss of the entire finger.

Loss of *not more than* one phalanx of thumb or any toe equals one-half the loss of the entire member.

Loss of *not more than* one phalanx of any finger (not thumb) equals the loss of one-third of the finger.

Loss of *more than* one phalanx, but *not more than* two phalanges of any finger (not thumb) equals the loss of one-half of the finger.

| | |
|---|---|
| Total and permanent disability | 500 weeks |
| Loss of one eye | 175 weeks |
| Loss of both eyes | 500 weeks |
| Loss of hearing, one ear | 75 weeks |
| Loss of hearing, both ears | 200 weeks |
| Loss of one testicle | 50 weeks |
| Loss of both testicles | 150 weeks |

Facial disfigurement—up to 200 weeks, except that payment for disfigurement is *not* payable if compensation is payable for any other permanent impairment.

| | |
|---|---|
| Loss of both hands | 500 weeks |
| Loss of both feet | 500 weeks |
| Death: | |
| For incidents occurring before 1 April, 1965, and resulting in death | 400 weeks |
| For incidents occurring on and after 1 April, 1965 and resulting in death | 450 weeks |

Maximum compensation payable in any case (excluding payments for medical and hospital bills)

For incidents occurring before 1 April, 1965—$16,500

For incidents occurring on and after 1 April, 1965—$20,000.

By using this schedule as a guide, the physician can more realistically and accurately arrive at a good estimate of permanent impairment. If the impairment does not lend itself to comparison with this schedule, the physician should try to evaluate realistically and equitably the functional impairment of the person as a whole. In cases of impairment of *more than* one finger or toe, the impairment should be expressed as impairment of the arm below the elbow or of the leg below the knee. In such cases, the doctor can add up the percentages of impairment of each finger (or toe) and add a small amount or percent to take care of the impairment to the hand or leg as a whole. Impairments should be estimated as percentage of the member in question (if only that one member is involved) or as percentage of a man as a whole. For instance: The loss of a thumb is worth 60 weeks; the arm *below the elbow* is worth 200 weeks; a man as a whole (still living) is worth 500 weeks. So the loss of the thumb can be related to the arm as 60/200, or 30% of the arm below the elbow, or as 60/500 or 12% of a man as a whole.

As stated earlier, an estimate of permanent

impairment should be reported at the first visit, and amended in subsequent reports as conditions dictate. The final estimation of permanent impairment should *not* be made until the condition has healed, rehabilitation (if any) has been given and the condition has reached a *permanent*, or *static* stage. The various publications of the AMA on evaluation of impairment can be of great help in evaluating impairment. During the years the law has been changed, and in the years to come more changes are likely to come about—so try to keep up to date on any changes. Most of the changes have been in the field of the weekly compensation.

## SUMMARY

The following, prepared by the California State Medical Association, and published in *California Medicine* 97:122, Aug., 1962, gives an excellent summary about the practice of industrial medicine:

### "THE INDUSTRIAL 'BLANK CHECK'"

"No physician in his right mind would sign a financial agreement involving thousands of dollars without a thorough knowledge of its contents and implications. Yet every day, physicians submit industrial accident reports involving vast sums of money with hardly a second thought.

"Standard forms or narrative reports concerning industrial injuries have important, unique characteristics. They are legal documents as well as medical records. They are often the sole basis on which large amounts of money are committed or actually paid in awards, litigation costs and disability payments. They may also have significant effect on the employment status of the insured worker.

"Making initial reports accurate, clear and concise best serves the best interests of all parties. Anything less may result in confusion and injustice, and is, moreover, harmful to the reputation of the individual physician and of the profession.

"Minimum requirements are:

"1. The patient's statement of how the alleged injury occurred.

"2. An accurate diagnosis—if this can be stated with assurance. The use of such terms as 'aggravation' or 'recurrence' is helpful in clarifying the relationship of the injury to pre-existing conditions. When exposure to irradiation or other harmful agent is alleged, but no immediate verification of exposure is available, 'suspected exposure' should be stated in the report. *Any diagnosis that is not substantiated should be omitted.*

"3. A precise statement of disability—both subjective and objective—with accurately stated measurements of function. The physician's own evaluation of the validity of the apparent disabling factors should be stated when indicated.

"4. Realistic estimates of the duration of disability—total or partial. Overly optimistic prognostications cause unnecessary, costly reappraisals and are discouraging to the worker, to the employer and to his insurance carrier. Any anticipated permanent impairment should be stated on *each* report and estimated with all possible accuracy.

"5. An indication of the need for further treatment and the kind of treatment.

"6. Finally—and important—the physician must sign the report himself. The responsibilities that the physician has to the patient, to the employer and himself are too great to be delegated to an aide.

"Don't be guilty of handing out '*industrial blank checks.*' They *can* bounce with most embarrassing consequences."

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10. Medical Relations in Workmen's Compensation (AMA publication).


Dr. Haggard has also, through his position with the Social Security Board, prepared an article, "Social Security Disability," which is being carefully reviewed by the commission as a whole, and further circulation of this article is anticipated.

Your Chairman, Lowell W. Painter, attended the meeting of the Committee on Environmental

Health of the American Medical Association in Chicago. That program dealt almost entirely with the presentation of the problems and very little time was spent on the solutions. It is hoped that in another year attempts will be made toward solutions of these problems since most of them are quite evident. The meeting was extremely interesting, well attended and most states had representatives there. Valuable contacts with members from other states were made, and it is recommended that representation from Indiana be continued at this meeting which is expected to be held annually.

In addition to the above recommendation, it is further recommended that an attempt by this committee should be made to assist better understanding of the Workmen's Compensation Act of Indiana, improved communications among physicians regarding these subjects and work to improve better liaison understanding with the industrial management representatives, the insurance industry and the legal profession.

LOWELL W. PAINTER, M.D., *Chairman*

**Committee for Preventive Medicine and Liaison with the State Board of Health**

During the past year, the Committee for Preventive Medicine and Liaison with the State Board of Health has had many incidental questions referred to it from various sources. Most of these have been along the line of the case findings, reporting and aiding when it was necessary in the treatment of contagious or infectious diseases. This has been particularly the case with the tuberculosis problem.

The committee was consulted regarding the problem of anti-microbial drugs for the treatment of indigent patients afflicted with tuberculosis. The committee has been very active in the coordinating committee for the eradication of tuberculosis in Indiana and had recommended to the State Board of Health, "If the patient is indigent, the drugs should be provided through the proper governmental agency." Communications from the State Board of Health confirm this and stated that, "Henceforth, beginning July 1, 1965, the State Board of Health will issue to any physician in the State upon written request a reasonable supply of drugs for patients being treated in the home for whom payment for the medication is considered a financial hardship." It is emphasized that this patient must be under treatment by the physician, and the case must be duly reported.

A letter was prepared to be sent to county societies to get a representative from each county for the T.B. Coordinating Committee. This is to be delivered to the Council by the commission.

Many requests have come from voluntary health agencies which have been duly considered.

The committee recommends that this continued liaison with the voluntary and governmental health agencies be continued. It does not seem feasible, however, that the state medical association should, as an association, hire inspectors or consultants to work for or with the agencies.

GERALD F. KEMPF, M.D., *Chairman*

**Committee on Rural Health and Physician Placement**

I. A. This committee has continued in its tradition of many years to support a long standing policy of Indiana State Medical Association for mutual assistance of communities and physicians to achieve satisfactory solution of problems of equitable supply of medical services.

B. Primary in the function of this committee continued to be emphasis of the many assets of rural general practice.

C. This was again implemented by utilization of the Junior-Senior Day program format. The program was held on March 27, 1965, at the Columbia Club with about two hundred and fifty students, wives, sweethearts and guests. Several IAGP officers and wives were also present to help answer questions of our "targets" (students and their guests).

D. The assistance of the Indiana University School of Medicine in publicizing the program was most helpful—also the cooperation of the IAGP organization and their participation helped in the continued expansion of the impact of this educational endeavor.

E. The highlight of the program for several years has been the "open panel" for answering any and all questions from the floor and many of these guests continue into the later portions of the program following the official conclusion.

F. It is the feeling of the committee, with endorsement of the commission and most of the Indiana State Medical Association officers and staff, that this program is one of the most valuable in liaison with medical students. The inclusion of wives and sweethearts may be one of the most important aspects of the program.

G. The committee is most grateful to Mead Johnson Company and Blue Shield for their continuing support of this program.

The committee recommends a special commendation to both organizations for their support.

H. The ISMA staff deserves a special plaudit for their publicity talents. *AMA News*, May 31, 1965, carried a special report of this meeting. In view of AMA Council on Rural Health ignoring our continuing program this is no small accomplishment.

This committee recommends the continuation of this program.

II. The influence of this commission, its individual members, and the ISMA program of "placement" has been very important on the Indiana medical scene. Many effects are known, but many others may not be obvious.

Continued liaison with other rural organizations, AMA, Farm Bureau, Grange, etc., will help medicine fulfill its obligation to the Indiana populace.

Also, liaison with IAGP in its programs, GP

Clubs, help with Junior-Senior Day—and other mutual programs will benefit all medical advances in Indiana.

FORREST J. BABB, M.D., *Chairman*

### Committee on Traffic Safety

During the past year the Traffic Safety Committee has continued to work with governmental and voluntary health organizations, as well as individuals concerned with traffic safety in Indiana.

It seems rather difficult, from a realistic standpoint, to coordinate this into an effective program —from a mechanical standpoint, much has been achieved through engineering of vehicles and highways, but the greatest source of traffic injuries and fatalities still remains in the area of human behavior. Because of this, further emphasis must be placed upon driver capability and driver education and information.

It seems that governmental control, legislation and police activity have not provided adequate incentive to improve driver behavior. Ideas are being explored and plans developed with responsible and knowledgeable persons of Indiana University and other interested agencies to facilitate the physicians role in driver training and education.

Further study will be given to the minimal standards for licensing drivers in the various categories of licensing.

THOMAS O. MIDDLETON, M.D., *Chairman*

### Committee on Conservation of Hearing and Vision

The Committee on Conservation of Hearing and Vision has been maintained and alert to various aspects pertaining to all ages and various activities. No specific questions have been referred to the committee.

It is recommended that better liaison be developed with school nurses and physicians, particularly pertaining to grade school children—eye protection from injury in both children and adults should have further attention. Visual defects and their correction should have continued consideration.

It is recommended that a further study of minimal standards for vision in the various occupations should be made.

BERNIECE M. WILLIAMS, M.D. *Chairman*

In addition to the above formal committee reports, the commission carefully considered the preparation of a resolution which was presented to the Council, and approved by the Council on July 17, regarding the Surgeon-General's report on Smoking and Health. Because of various stated reasons, it was resolved that the Indiana State Medical Association commend the Surgeon-General's report on Smoking and Health, reaffirm our previous action and promote the dissemination of information contained in this report and the conclusions therefrom to the people of Indiana in any manner consistent with dignity and good taste.

### RESOLUTION

WHEREAS, the Surgeon General's report on Smoking and Health is a carefully, comprehensively and scientifically prepared resume of scientific data accumulated relating to smoking and health; and

WHEREAS, the conclusion of this report establishes beyond reasonable doubt that smoking represents a significant health hazard; and

WHEREAS, one of the purposes of the Indiana State Medical Association is to aid and improve and protect the health of the people of Indiana; and

WHEREAS, it is one of the prime purposes of the Indiana State Medical Association to disseminate through its members, and otherwise, information concerning health hazards and general means of improving the health of the people of Indiana;

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association commends the Surgeon General's report on Smoking and Health and reaffirms our previous action to promote the dissemination of the information contained in this report and the conclusions therefrom to the people of Indiana in any manner consistent with dignity and good taste.

The Commission on Public Health hereby recommends that the present general structure and scope of activities and organizational structure should be continued. Long range planning of the programs seems most important for these projects.

It is further suggested that an increasing use should be made of members of the state medical association who have special abilities, experience or information, by the commission for ex-officio members or ad hoc committees.

Particular further emphasis must be placed upon an effort in T.B. as to case finding and education—physical education in the schools, especially as pertaining to athletic programs and also general health education in our public schools. Any and all projects or problems concerning the area of general public health must be considered of interest and in the prerogative of the Commission on Public Health.

EMMETT B. LAMB, M.D., *Chairman*
GERALD F. KEMPF, M.D., *Vice-Chairman*
BERNIECE M. WILLIAMS, M.D., *Secretary*
ARNOLD W. BROCKMOLE, M.D.
THOMAS O. MIDDLETON, M.D.
SAMUEL L. ADAIR, M.D.
R. M. SEIBEL, M.D.
WILSON L. DALTON, M.D.
JOHN B. HICKAM, M.D.
LOWELL W. PAINTER, M.D.
FORREST J. BABB, M.D.
JACOB FLEISCHER, M.D.
T. NEAL PETRY, M.D.
JOHN P. TURNER, M.D.
H. GLENN GARDINER, M.D.
DANIEL GARD, M.D., *Ex-Officio*
E. S. JONES, M.D., *Ex-Officio*
WILLIAM BAUGHN, M.D., *Ex-Officio*

A. C. OFFUTT, M.D., *Ex-Officio*
LOUIS SPOLYAR, M.D., *Ex-Officio*
E. B. HAGGARD, M.D., *Ex-Officio*
RALPH WILMORE, M.D., *Ex-Officio*
WARREN TUCKER, M.D., *Ex-Officio*
JOHN A. DAVIS, M.D., *Ex-Officio*
E. S. RIFNER, M.D., (*Consultant*)

## Voluntary Health Agencies

This commission is made up of the following:

(1st Distr.) James R. Mathews, 715 First Ave., Evansville

(2nd Distr.) Herbert O. Chattin, 729 Main St., Vincennes

(3rd Distr.) William R. Noe, 2900 W. 16th St., Bedford

(4th Distr.) Robert Acher, 221 E. Washington St., Greensburg

(5th Distr.) Stuart R. Combs, 3050 Poplar St., Terre Haute

(6th Distr.) Lucian A. Arata, 327 W. Broadway, Shelbyville

(7th Distr.) Norman R. Booher, 447 E. 38th St., Indianapolis

(8th Distr.) Alton H. Ridgway, Lapel

(9th Distr.) Albert E. Applegate, 1303 S. Jackson St., Frankfort

(10th Distr.) Walfred A. Nelson, 559 S. Lake St., Gary

(11th Distr.) Wendell W. Ayres, 500 Wabash Ave., Marion

(12th Distr.) Robert G. Taylor, 2902 Fairfield Ave., Fort Wayne

(13th Distr.) William F. Oren, 919 E. Jefferson Blvd., #301, South Bend

(At Large) Wendell A. Shullenberger, 1815 N. Capitol Ave., Indianapolis

(At Large) James H. Gosman, 2901 N. Meridian St., Indianapolis

(Consultant) Doris H. Merritt, 1100 W. Michigan St., Indianapolis

The organizational meeting of the commission was held November 1, 1964, and the following officers were elected: Norman R. Booher, M.D., Chairman; James H. Gosman, M.D., Vice-Chairman; and Lucian A. Arata, M.D., Secretary.

To reiterate for the House of Delegates, the work of this commission is to establish liaison with and seek information about all voluntary health agencies having a state-wide program in Indiana and to apply agreed upon criteria in order that the Indiana State Medical Association grants recognition to those voluntary agencies meeting these criteria.

The criteria upon which these agencies are judged for recognition are as follows:

1. Must conform to fund raising practices of National Social Welfare Assembly.
2. Must request approval by the Indiana Medical Association and agree to utilize qualified medical guidance from the association to an adequate degree in planning and implementing medical and research activities.
3. Must clearly define its relationship (if any) with a national group in regard to its status or degree as ancillary or independent unit.
4. Must state fully its purpose and objectives as related to health services and medical care and research.
5. Must demonstrate adequately its objectives and fund goals are realistic when related to actual needs.
6. Must show that cost of fund raising and administration is reasonable in relationship to total expenditures towards its stated objectives.
7. Must show that educational and promotional materials used are medically sound and presented in good taste.
8. Must relate its expenditures and services to needs for such services and to established medical care patterns.
9. Must justify its research expenditures by morbidity and mortality incidence and research needs.

The criteria in use have been strengthened in the current year by the completion and publication of the *Uniform Standards of Accounting for Voluntary Health Agencies* by the National Health Council. These uniform studies are being adopted widely and allow financial comparisons to be more accurate.

The following agencies have been recognized for this past year:

1. The American Cancer Society, Indiana Division.
2. Indiana Chapter of The Arthritis Foundation—conditional recognition during their period of transition and recommended to them that they make every effort to bring all the counties into the state chapter.
3. Indiana Society for Prevention of Blindness.
4. The Indiana Society for Crippled Children and Adults, Inc.—recognized—with suggestion that they consider problems of overlapping.
5. Tri-State Epilepsy Society, Inc.
6. Indiana Heart Association, Inc.
7. Kenny Foundation—qualified recognition—pending review in a year of their Indiana experiences, as reorganized.
8. Indiana Association for Mental Health.
9. National Multiple Sclerosis Society (Indiana Chapter).
10. Myasthenia Gravis Foundation, Inc. (Indiana State Chapter)—recognized in 1964—but 1965 questionnaire not received as yet.
11. Indiana Association for Retarded Children, Inc.
12. Indiana Tuberculosis Association.
13. United Cerebral Palsy of Indiana, Inc.

The following agencies have not been recognized for this past year:

1. Aiding Leukemia Stricken American Children—not recognized for failure to meet our criteria.

2. City of Hope—not recognized for lack of information.

The National Foundation has been given qualified recognition because they still have not recognized the stated policy of the American Medical Association that physicians be members of the board of directors of national voluntary health agencies.

The following county agencies, previously dealt with, have now been referred to their county medical society:

1. Allen County Cancer Society.
2. The Indianapolis Diabetes Association.
3. Marion County Cancer Society, Inc.
4. Cancer Society of St. Joseph County.
5. Social Health Association of Indianapolis.

In an effort to inform all the members of this association of the activities of this commission, a letter was sent out under date of February 10 to the presidents of all constituent county medical societies. This letter not only gave the factual information indicated but urged each county to provide for a similar committee on voluntary agencies for dealing with voluntary agencies operating on a county basis. This letter was a substitute for the action authorized by the House of Delegates last year for publicizing the new *AMA Directory on National Voluntary Health Agencies.*

During its meetings, the commission has sought information pertinent to its work from national sources and devoted a large part of one of its meetings to hearing representatives of the United Health Foundation, Inc.

The commission has kept in touch with national developments by virtue of the fact that the chairman is a member of the American Medical Association Council on Voluntary Health Agencies.

Some of the national developments of interest to the house include additional information confirming the opinion held by the commission about some of the national agencies, particularly the National Foundation, and the idea of accreditation, as established in Indiana, and a few other states, is now being seriously planned on a national scale.

At its final meeting on June 6, the following action was taken by the commission:

"Based on experience gleaned from other areas on the subject, it was decided to ask the House of Delegates to allow this commission to create an Advisory Committee to the Indiana State Medical Association's Commission on Voluntary Health Agencies.

"The purpose of this advisory committee, initially, would be: (1) To provide a media of communication with other purveyors of health services and planning; (2) to upgrade and consolidate the educational programs of the voluntary agencies, both for profesional and lay people; and (3) to advise the commission in its relationships with voluntary agencies.

"Initially, some of the organizations that would be invited to participate in such an advisory committee are the executive secretaries and presidents of all voluntary health agencies having a statewide program in Indiana and: (1) State Dental Association; (2) State Veterinarians' Association; (3) State Pharmaceutical Association; (4) State Nurses Association; (5) State Hospital Association; (6) Association of Industrial Nurses; (7) State Association of Nursing Homes; (8) State Chamber of Commerce; (9) Department of Public Welfare; (10) State Board of Health; (11) Indiana University School of Medicine; (12) Industrial Aid for the Blind; (13) Department of Public Instruction; (14) State Department of Mental Health; (15) Indiana Health Careers; (16) Division of Public Health Nursing of the State Board of Health; (17) Maternal Health League of Indiana; (18) Blue Cross; (19) Blue Shield; (20) State Teachers' Association; (21) Parent-Teachers' Association; (22) American Legion; (23) AFL-CIO (24) Representatives of metropolitan Better Business Bureaus; (25) Indiana Federation of Churches; (26) Hoosier State Press Association; (27) Council of United Funds; (28) United Health Foundation; (29) Indiana Broadcasters Association; (30) Indiana Manufacturing Association; (31) Indiana Retail Council (32) Farm Bureau; (33) Indiana State Bar Association; (34) Indiana Public Health Nurses Association; (35) Indiana Health Officers' Association and (36) Indiana Public Health Association.

"As this committee program develops, it will probably be feasible to adjust the members of this Advisory Committee from time to time."

Finally, several members of the commission have terminated long service on the commission and the association is in their debt.

I would like to thank all of the members of this commission who have spent many hours in its work and the work of organized medicine and would especially like to thank Mr. James Waggener and Mr. Kenneth Bush for their cooperation, and, above all, Miss Eleanor Chapple, who has served as secretary and has carried on the voluminous correspondence of this commission.

NORMAN R. BOOHER, M.D., *Chairman*

## Medical Economics and Insurance

The commission met on Nov. 22, 1964, Jan. 24, 1965, Apl. 24, 1965, and July 18, 1965.

President Black's innovation of assembling all commissions prior to their separate meetings served a very useful purpose towards motivation out of the depressing effects of the last national election by giving us a feeling of unity of purpose. This commission recommends a continuance of this policy.

The various categories assigned to this commission by the Consitution and Bylaws of the ISMA were kept under surveillance this year with numerous minor problems apparently relegated to the "Let's wait and see" file because of the pending federal legislation.

Blue Shield problems were not a topic of discussion at any time this year. We found no motivation towards retirement plans. Tax problems remained the same. Utilization committees and in-

surance review committees appeared to be satisfactorily seeking their own levels of usefulness in various localities. Our psychiatrists on the commission kept us informed on the progress of a new mental health legislation and its relationship to psychiatric practice in the state of Indiana. Professional liability and malpractice problems, workmen's compensation problems and labor's problems on medical and hospital care were all quiet this year.

Driver's insurance presented a problem in the form of a contention that many physicians are being called upon to "underwrite" the ability of individuals over age 65 to drive a car safely. The ISMA legal department was asked to give us a ruling as to whether or not a physician was answerable for loss or damage by signing his name and attesting to the apparent ability of individuals to drive a car. This question has not been answered to date.

Military Medicare presented a rather ridiculous problem by refusing to process anesthesiologists' claims until they received the surgeon's claim. This problem was resolved by correspondence between Mr. James Waggener and the office of the Surgeon General, U. S. Army.

For the past two years most of our energies have been directed towards obtaining an Association Group Disability Insurance Program. By the time of the October meeting of the House of Delegates, it is expected that this program will be finalized and ready for presentation. Mr. J. Russell Townsend, Jr., 811 Board of Trade Building, Indianapolis was appointed as agent of record. With his assurance, we believe that we have a quality program that is based upon sound actuarial principles and capable of supplementing any basic disability plan satisfactorily. A dignified but aggressive enrollment program is planned and will consist of (1) mailings (2) appearances before medical groups (3) personal interview *only* at the request of the physician. This program can be kept young by routine solicitation of new members of ISMA as soon as the association office notifies the agent of record. It will provide a maximum of $800.00 of monthly indemnity and will cover flying physicians. It has both short-term and long-term programs and a senior plan for those 70 years and over as long as they live and are actively engaged in their profession.

I wish to express my personal appreciation to each member of this Commission on Medical Economics and Insurance who have given so unselfishly of both time and effort this past year and as always to Mr. James Waggener and his staff for their cooperation and counseling.

JACK W. HANNAH, M.D., *Chairman*
WILLARD T. BARNHART, M.D., *Vice-Chmn.*
THOMAS HAMILTON, M.D., *Secretary*
JOHN W. BEELER, M.D.
JAMES BILLS, M.D.
THOMAS J. CONWAY, M.D.
WILLIAM H. GARNER, M.D.
ELDRED F. HARDTKE, M.D.
JOSEPH L. LARMORE, M.D.
JAMES M. LEFFEL, M.D.
JOHN F. LING, M.D.
WILLIAM SCHARBROUGH, M.D.
CHESTER A. STAYTON, JR., M.D.
W. R. VAN DEN BOSCH, M.D.
RICHARD WAGNER, M.D.

## Inter-Professional Relations

The Commission on Inter-Professional Relations has been mainly occupied with two subjects.

The first of these has been the assignment to formulate a definite program whereby a county medical society or societies may determine which osteopaths qualify for professional relations on an ethical basis. The commission is ready to report to the Council on this subject at the next meeting of the Council; since it is hoped that modification and/or elaboration of the recommendations may be made by the Council, no detail of these recommendations is in order here.

The second subject has been the development of a code of inter-professional relations with the Indiana Pharmaceutical Association. Our sub-committee has had meetings with representatives of the Pharmaceutical Association and reports that a tentative code of understanding has been developed and that copies of this should reach commission members within a few days of the date of this report.

CHARLES X. McCALLA, M.D., *Chairman*
JOHN W. RIPLEY, M.D., *Vice-Chairman*
A. WAYNE RATCLIFFE, M.D., *Secretary*
ROBERT H. RANG, M.D.
PAUL HUMPHREY, M.D.
FRANK H. GREEN, M.D.
FLOYD A. BOYER, M.D.
ROBERT D. WILLIAMS, M.D.
FRED FLORA, M.D.
MILTON B. GEVIRTZ, M.D.
JOSEPH B. DAVIS, M.D.
JACK L. EISAMAN, M.D.
ROBERT H. DENHAM, JR., M.D.
NEAL E. BAXTER, M.D.
E. ROBERT JACOBS, M.D.

## Medical Education and Licensure

Your commission has worked hard and long, individually and collectively, during the past year to bring to fulfillment some projects and to institute others. Each member of the commission deserves a sincere thanks and endorsement for the work accomplished. Meetings were well attended and vigorous. Much was done and much needs yet to be done.

The most recent meeting of the commission members was with the faculty heads and dean of the Indiana University Medical School. This was the second annual meeting of these two groups and serves as a place for free give-and-take of ideas which we feel will lead to better understanding and a progressive outlook of medical education in its formal or university sense. The preceptor program has continued steadily this past year due to the fine cooperation of the university and the com-

mission feels that augmentation of the program is the next step in its natural development. Our greatest need is for volunteer preceptors and we trust that the members of the Indiana State Medical Association will answer the call of this need. The program works only if you make it work.

During the course of the regular meetings, new ideas and methods relative to postgraduate education were discussed and were under investigation. The many facets of postgraduate education were explored and a recent survey, sometimes controversial, will, it is felt, help us in establishing better modalities of presentation.

Numerous problems in our area have been discussed, and in most instances, the commission members have been very helpful in bringing them to solution. Other areas, such as school health and physicians, are continuing to be worked on.

Another major activity of the group was in the field of licensure liaison with a member of the board of licensure present for one full meeting and a liaison meeting between all members of both groups. Free transmission of ideas and attitudes has been a great help in clarifying the positions of the two groups relative to licensure and increasing the number of practicing physicians in our state. There is much in a concrete way that can be done but this has been a start and we feel that it is a good one.

In closing, I wish to repeat that this commission is an admirable and active group and no written report can do justice to the work and industry shown by the members. They all have my heartfelt thanks with the admonition, "Don't quit while you're ahead."

Sub-Committees of Commission on Medical Education and Licensure:

*Postgraduate Education:*
Harry Klepinger, M.D.
Walter Vaughn, M.D.

*Medical Licensure:*
Forrest R. LaFollette, M.D.
Leo Radigan, M.D.
John Sterne, M.D.

*Preceptor Program:*
Kenneth E. Sherer, M.D.
Earl W. Bailey, M.D.
George T. Lukemeyer, M.D.

PETER R. PETRICH, M.D., *Chairman*
JOEL SALON, M.D., *Vice-Chairman*
FORREST R. LaFOLLETTE, M.D., *Secretary*
JOHN STERNE, M.D.
WALTER VAUGHN, M.D.
JOHN M. PARIS, M.D.
I. S. TEMPLETON, M.D.
JAMES B. JOHNSON, M.D.
KENNETH E. SHERER, M.D.
GEORGE T. LUKEMEYER, M.D.
JOHN L. CULLISON, M.D.
LEO RADIGAN, M.D.
EARL W. BAILEY, M.D.
JAMES R. CARPENTIER, M.D.
HARRY KLEPINGER, M.D.

## Special Activities

During the current year, the Commission on Special Activities has held three formal meetings. Reports of progress of the AMA-ERF program have been reviewed with satisfaction about the success of this program in the state of Indiana.

The members of the commission spent considerable time in individual studies of material concerning impartial medical witness programs.

As a result of our studies, we felt that the possibility of instituting such a program in the state of Indiana deserved further exploration by our committee with representatives of the Indiana Bar Association.

We regret to report that, despite letters of invitation and phone calls from members of our committee to the Bar Association, we were unable to arrange a joint meeting with its members.

We feel that our effort to arrange a meeting with the Bar Association in this matter was explicit and sincere.

We feel that the medical profession of Indiana has now made a sincere effort to solve the so-called "medical witness problem."

ELI GOODMAN, M.D., *Chairman*
NORBERT M. WELCH, M.D., *Vice-Chairman*
HAROLD C. OCHSNER, M.D., *Secretary*
JOSEPH E. COLEMAN, M.D.
ROBERT O. ZINK, M.D.
NORMAN M. SILVERMAN, M.D.
JOHN SMITH, M.D.
JACK M. WALKER, M.D.
CLARENCE G. KERN, M.D.
ARTHUR KUHN, M.D.
EARL W. BAILEY, M.D.
DAVID C. GASTINEAU, M.D.
JAMES D. KUBLEY, M.D.
GUY B. INGWELL, M.D.
WES SHANNON, M.D.

## Aging

The Commission on Aging has held three formal meetings during the year, in addition to a subcommittee's efforts to set up a state-wide Conference on Aging in conjunction with the State Board of Health. The aim is to bring together representatives of health professions and community groups to explore joint action in meeting the needs of older people and long-term patients. The seminar will emphasize the concept of independent living for the elderly.

The commission, with the aid of the headquarters office of the Indiana State Medical Association, drafted and mailed letters to Senator Robert P. O'Bannon, chairman of the Finance Committee and Representative William Sebree, chairman of the House Ways and Means Committee, expressing their interest in the passage of Senate Bill No. 130. The bill was enacted by the 94th regular session of the General Assembly and is entitled, "An Act directing the State Board of Health in conjunction with the Indiana Legislative Advisory Commission to conduct a study of independent

living," Chapter 85, Acts of 1965.

The county medical society should examine its role in area-wide planning of hospital and related health facilities. Area-wide planning is a process whereby local communities assess their health needs and provide for these needs on a coordinated basis. It has been recognized by the AMA House of Delegates as an important method for providing facilities, and that through the elimination of duplication of facilities, such planning could have an important impact on hospital care costs.

GLEN A. RAMSDELL, M.D., *Chairman*
GEORGE M. YOUNG, M.D., *Vice-Chairman*
FRANK M. HALL, M.D., *Secretary*
BERNARD B. ROSENBLATT, M.D.
C. PHILIP FOX, M.D.
WILLIAM B. CLARK, JR., M.D.
HARRY R. BAXTER, M.D.
FRED W. DIERDORF, M.D.
WARREN ANDREW, M.D.
RALPH R. PLOUGHE, M.D.
F. S. CROCKETT, M.D.
GEORGE W. WAGONER, M.D.
NATHAN SALON, M.D.
N. C. JOHNS, M.D.
ANDREW C. OFFUTT, M.D.

# Resolutions

## Resolution No. 1

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
**Subject:** RESOLUTION AGAINST AREA-WIDE HOSPITAL CONTROL

WHEREAS, Congress has authorized the appropriation of $22,500,000.00 for a study of area-wide hospital planning over a five-year period that started in 1964, and,

WHEREAS, the American Hospital Association Board of Trustees has circulated a folder saying that "The state government should be authorized to deny licenses for projects that are not approved under the regional plan", and,

WHEREAS, the State of New York has already adopted such a dogmatic control in its Metcalf-McClosky Law, and,

WHEREAS, the adoption of such a state law in Indiana would be detrimental to the best type of medical care by virtue of third party political interference,

NOW THEREFORE BE IT RESOLVED, by the Daviess-Martin County Medical Society in regular session this 15th day of February, 1965, that we request the delegates of the 1965 session of the Indiana State Medical Association to pass a resolution against such control of hospitals and related health facilities by any state agency.

## Resolution No. 2

**Introduced by:** LAGRANGE COUNTY MEDICAL SOCIETY
**Subject:** NON-PARTICIPATION IN HR-6675

WHEREAS, the practice of private medicine has provided residents of the United States with the highest quality medical care, and,

WHEREAS, the Mills bill, HR-6675, proposes a government program of socialized hospitalization and medical care of the aged, and,

WHEREAS, such a program would destroy the patient-physician relationship so essential to the best medical care and by regimenting physicians and their patients will lead to inferior medical care, and,

WHEREAS, non-participation means that physicians will continue to serve their patients as before but will refuse to deal with a third party that intrudes into the private relationship between patients and their physicians,

NOW THEREFORE BE IT RESOLVED, that the members of the LaGrange County Medical Society (Indiana) oppose HR-6675 and all similar legislation, and pledge ourselves, individually, not to participate in HR-6675 or any similar legislation, and,

BE IT FURTHER RESOLVED, that all members of the Indiana State Medical Association express the same opposition to this legislation.

## Resolution No. 3

**Introduced by:** MADISON COUNTY MEDICAL SOCIETY
**Subject:** NON-PARTICIPATION IN MEDICARE AND/OR OTHER GOVERNMENTAL MEDICAL PROGRAMS

WHEREAS, the practice of private medicine has provided the residents of the United States with the highest quality medical care obtainable, and,

WHEREAS, the Mills bill, HR-6675, proposes a government program of hospital and medical care which must inevitably intrude into and disrupt traditional medical relationships, and,

WHEREAS, all such government programs destroy the patient-physician relationship, which we regard as essential to the highest quality medical care, and,

WHEREAS, we regard it to be our moral and ethical obligation to take whatever steps may be necessary to protect our patients from such inferior care, and,

WHEREAS, non-participation is the only remaining ethical, legal, and morally right method of protecting our patients from such inadequate and inferior care, and,

WHEREAS, non-participation requires that we, as physicians, will continue to care for and serve our individual patients, we will refuse to accept government intrusion into the private patient-physician relationship,

NOW THEREFORE BE IT RESOLVED, that the members of the Indiana State Medical Association at its regular meeting, on October 14, 1965, oppose HR-6675 and all similar measures, and,

BE IT FURTHER RESOLVED, that we, as individual members of the Indiana State Medical Association, announce our determination to refuse to participate in all such schemes of providing medical care and to encourage all other ethical physicians to do likewise.

## Resolution No. 4

**Introduced by:** THE COUNCIL
**Subject:** REALIGNMENT OF PHYSICIAN POLICY RE: THIRD PARTIES

WHEREAS, the physicians of this nation have advocated for generations constructive programs for the betterment of the public health, and,

WHEREAS, physicians have been responsible for the enactment of most of the laws in the interest of health, and,

WHEREAS, the longevity of our people has increased under present day medical care, and,

WHEREAS, physicians have, over the years, contributed their services either without charge to those in need when money was not available to pay for their services or at greatly reduced fees to provide the highest quality care for veterans, those on Old Age Assistance, and all other tax financed programs, and,

WHEREAS, in spite of the aforementioned char-

itable activities of physicians to relieve the needs of the sick on a gratuitous or semi-gratuitous basis and in spite of the pre-eminence of the nation's health care under our present fee for service system, and,

WHEREAS, there are those who now choose to impose a system of government-dictated medical care, which the physicians have pointed out is dangerous from an economic and quality standpoint, and,

WHEREAS, the government now proposes to pay for the care of all over 65 regardless of need, under an increased tax program, eliminating the classification of needy cases but instead proposes to treat the needy and self-sufficient aged as equals,

NOW THEREFORE BE IT RESOLVED, that the physicians of this state adopt the same position for payment of their services as other purveyors of goods and services under federally-supported programs, and,

BE IT FURTHER RESOLVED, that physicians inform all third parties that effective January 1, 1966, physicians will participate only on the basis they receive their usual and customary fee for like services as paid for by the private paying patients, and,

BE IT FURTHER RESOLVED, that usual and customary fees be defined as follows:

"*Usual* — The 'usual' fee is that fee usually charged for a given service, by an individual physician to his private patient (i.e., his own usual fee).

"*Customary* — A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."

## Resolution No. 5

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
**Subject:** RESOLUTION ON DUES

WHEREAS, the five page mailing of September 4, 1964 to all members of the ISMA was replete with needless demands for more operating expenses, and,

WHEREAS, the same mailing could have requested the member's opinion on the plans for expanded activities, and,

WHEREAS, adequate time for exchange of opinions on this matter between county society members was not available for instructions to be given to delegates to the ISMA meeting, and,

WHEREAS, some societies had no delegates representing them at this annual meeting, and,

WHEREAS, the dues increase voted for by the House of Delegates in October, 1964, is but an introduction to further increases to be expected in the future if not now protested,

NOW THEREFORE BE IT RESOLVED, by the members of the Daviess-Martin County Medical Society, in regular meeting this 18th day of January, 1965, that continuation of present dues increase or future dues raising be decided on the basis of a referendum of the entire membership.

## Resolution No. 6

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
**Subject:** RESOLUTION AGAINST FEDERAL SUBSIDY OF MEDICAL CARE

WHEREAS, a Supreme Court decision* has said that it is not unreasonable for the Federal Government to control that which it subsidizes, and,

WHEREAS, the AMA delegates in June, 1964, opposed the federal subsidization of pre-payment plans and health insurance companies, and,

WHEREAS, the AMA this year is proposing the passage of an Eldercare Bill that violates the 1964 decision of the House of Delegates,

NOW THEREFORE BE IT RESOLVED, by the Daviess-Martin County Medical Society in official session this 15th day of March, 1965, that we do not sanction this switch in policy adopted by a special session of the House of Delegates of the AMA this year and request the ISMA to sponsor a resolution at its next annual meeting expressing this opinion.

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* Wickward vs. Filburn, 1942.

## Resolution No. 7

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
**Subject:** RESOLUTION ON MEDICARE

WHEREAS, it appears that HR-6675, the Medicare Bill of 1965, will become law, and,

WHEREAS, this is nothing less than a step toward socializing the practice of medicine, and,

WHEREAS, the current Congress refuses to heed the warnings of our profession to the effect that socialized medical care is inferior medical care, as has been proven by its history, and,

WHEREAS, the Daviess-Martin County Medical Society resolved, on 1/30/62, not to participate in medical care bills passed by a thoughtless Congress,

NOW THEREFORE BE IT RESOLVED, that the Daviess-Martin County Medical Society in regular session this 19th day of April, 1965, requests the Indiana State Medical Association to adopt a similar stand of non-participation in the 1965 Medicare Act.

## Resolution No. 8

**Introduced by:** PETER PETRICH, M.D., Councilor, Ninth District Medical Society
**Subject:** CREATION OF SECTION ON PEDIATRICS

WHEREAS, the Indiana Chapter, American Academy of Pediatrics is composed of in excess of

100 active members who are members of their component county medical societies and the Indiana State Medical Association, and,

WHEREAS, these members have met almost annually for a luncheon and scientific program, and,

WHEREAS, they have and will take active part in the scientific portion of the annual convention of the Indiana State Medical Association, and,

WHEREAS, the members of the Indiana Chapter, American Academy of Pediatrics, at their annual meeting in 1965 approved requesting formulation of a Section of the association—a Section on Pediatrics—in accordance with Article VII of the Constitution of the Indiana State Medical Association and under Chapter III, Section 1 of the Bylaws of the Association,

NOW THEREFORE BE IT RESOLVED, that a Section on Pediatrics be hereby approved and provided for by amendment of Chapter III, Section 1 of the Bylaws.

## Resolution No. 9

**Introduced by:** HAMILTON COUNTY MEDICAL ASSOCIATION

**Subject:** MASS ORAL POLIO ADMINISTRATION

WHEREAS, in October, 1962, the House of Delegates of the Indiana State Medical Association approved the policy concerning oral polio immunization:

(1) That oral immunization programs presently in progress be completed, except that Type III oral vaccine be withheld from adults.

(2) That new mass oral immunization programs are not encouraged except in epidemics or special local situations.

NOW THEREFORE BE IT RESOLVED, that subsequent studies and immunization programs on the safety and effectiveness of oral polio immunization find this policy to be no longer appropriate and that mass immunization may and should be considered on a county or city level.

## Resolution No. 10

**Introduced by:** WABASH COUNTY MEDICAL SOCIETY

**Subject:** SEPARATION OF PROFESSIONAL AND HOSPITAL FEES

WHEREAS, the practice of anesthesiology, pathology, physiatry and radiology is the practice of medicine, and,

WHEREAS, the services of physicians in those specialties cannot be considered hospital services, and,

WHEREAS, the practice of allowing the charges by those specialties to be incorporated in the fees charged by the hospital has resulted in (1) a public misconception that the services rendered by those specialities are being provided as part of hospital care and, (2) increasing hospital domination of those specialties,

NOW THEREFORE BE IT RESOLVED, that henceforth, the Indiana State Medical Association recommends that fees of anesthesiology, pathology, physiatry and radiology be charged separately from the fees of the hospitals and that in no event should the fees of those specialties be incorporated with the charges made by a hospital.

## Resolution No. 11

**Introduced by:** FORT WAYNE MEDICAL SOCIETY

**Subject:** RESOLUTIONS TO BE INTRODUCED AT ANNUAL CONVENTION

WHEREAS, publication of resolutions, many of which will not receive an affirmative vote by the House of Delegates of the Indiana State Medical Association, and the intent of many of which might be misconstrued by non-medical persons, in *The Journal of the Indiana State Medical Association* may create unfavorable impressions in the minds of the many non-medical persons who have access to *The Journal*, and,

WHEREAS, few county medical societies meet and transact business during the summer months so that the preparation of resolutions to come before the House of Delegates, and the forwarding thereof to the headquarters office of the Indiana State Medical Association prior to August 1st of each year may result in hastily and inadequately prepared resolutions,

NOW THEREFORE BE IT RESOLVED, that Chapter IV, Section 7, of the Bylaws of the Indiana State Medical Association be amended so that in paragraphs one and two the words "forty-five" shall be deleted and replaced by the word "twenty", and,

BE IT FURTHER RESOLVED, that the headquarters office of the Indiana State Medical Association shall prepare by lithotyping or a similar system of reproduction, and shall mail to each of its physician members and to each county society office, a copy of the resolutions received no later than twelve days prior to the regular annual meeting of the House of Delegates of the association.

## Resolution No. 12

**Introduced by:** TIPPECANOE COUNTY MEDICAL SOCIETY

**Subject:** OPTIONAL BLUE SHIELD COVERAGE FOR M.D.'S

WHEREAS, the physicians of Tippecanoe County feel the honored tradition of professional courtesy is a desirable adjunct of our professional ethics and interrelationships, and,

WHEREAS, we feel the practice of extending professional courtesy should be encouraged instead of supplanted, and,

WHEREAS, the existence of medical payments

insurance discourages the practice of professional courtesy and often embarrasses both the doctor and his physician-patient,

NOW THEREFORE BE IT RESOLVED, that the Tippecanoe County Medical Society hereby petitions the Indiana State Medical Association House of Delegates and Council to alter our group policy (Blue Cross-Blue Shield #9665) contract with Mutual Hospital Insurance, Inc., so that medical payments insurance is optional instead of mandatory when hospital insurance is purchased, and,

BE IT FURTHER RESOLVED, that each individual should be free to choose his own insurance coverage and that any physician may choose to buy or not buy medical payments insurance as he desires.

## Resolution No. 13

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** REPORT OF PRESIDENT'S COMMISSION ON HEART DISEASE, CANCER AND STROKE

WHEREAS, the President's Commission on Heart Disease, Cancer and Stroke has recommended sweeping changes in the existing pattern of medical education, research and patient care, including the establishment of regional centers for diagnosis, treatment and research, and,

WHEREAS, through a constantly improving pattern of the finest medical education and research in the world, and postgraduate education and improved diagnostic and therapeutic techniques, the American physician is prepared to render the best medical care,

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research and patient care, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association report findings and recommendations resulting from these conferences to the AMA Board of Trustees for the information of the board, the councils and the association members.

## Resolution No. 14

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** REPRESENTATION ON HILL-BURTON ADVISORY COUNCIL AND AREAWIDE PLANNING AGENCY

WHEREAS, the Indiana State Medical Association has inadequate representation on the Hill-Burton Advisory Council for Indiana and on our Areawide Planning Agency,

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association make every effort to provide adequate physician representation on the Hill-Burton Advisory Council for Indiana and on our Areawide Planning Agency.

## Resolution No. 15

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** CANCER REGISTRIES

WHEREAS, the protection and the improvement of the health of the American people are basic objectives of the American Medical Association and its component medical societies, and,

WHEREAS, cancer registries provide significant contributions to the advancement of scientific knowledge in the control of cancer,

NOW, THEREFORE BE IT RESOLVED, that medical staffs and county medical societies in Indiana be urged to encourage the establishment, maintenance and proper use of cancer registries in hospitals.

## Resolution No. 16

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** PAYMENT OF INTERNS AND RESIDENTS BY BLUE SHIELD PLANS

WHEREAS, there has been controversy in regard to the payment by Blue Shield Plans for professional services rendered by residents and interns, and,

WHEREAS, it is the policy of the American Medical Association that each physician shall be the sole arbiter of the ways in which he shall dispose of his professional income, consistent with the laws of the land and the Principles of Medical Ethics of the American Medical Association,

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association record itself as approving and supporting the principle that Blue Shield medical-surgical benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association report its action to the National Association of Blue Shield Plans and to all component county medical societies.

## Resolution No. 17

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** PHYSICIAN REPRESENTATION IN FEDERAL HEALTH CARE PROGRAMS

WHEREAS, there is a real need for competent advice by physicians practicing in the community on federal health care plans conducted locally,

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association seek the provision for and the appointment of representative

physicians as advisory committees in all federal programs which relate to health care.

## Resolution No. 18

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** STATE ASSOCIATION OF THE PROFESSIONS

WHEREAS, the experience of the Michigan State Medical Society has proved the merit of the establishment of a State Association of the Professions,

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association take a leadership role in the formation of an Indiana State Association of the Professions to provide a vehicle for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit.

## Resolution No. 19

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** COMMUNITY DEVELOPMENT OF EXPLORER SCOUT PROGRAM

WHEREAS, mutual benefits are to be gained from the development of Explorer Scout programs, the Indiana State Medical Association reaffirms its long-standing appreciation of the contributions of the Boy Scouts of America, and particularly commends Scouting's Explorer programs for medical specialty posts,

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urge component county medical societies to encourage widespread community development of the Explorer Scout program for medical specialty posts in Indiana.

## Resolution No. 20

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** I-HOPE

WHEREAS, I-HOPE has been organized to enable the medical profession and its allies to function as an effective force in the fields of political education and action, and,

WHEREAS, other state medical societies have authorized and endorsed the inclusion of a voluntary, non-deductible contribution for political education and action on these societies' annual billing statements, and,

WHEREAS, a ready opportunity to affiliate with I-HOPE is highly desirable, and,

WHEREAS, voluntary, automatic billing procedures provide this ready opportunity,

NOW, THEREFORE BE IT RESOLVED, that the Indiana State Medical Association approve the inclusion of a vountary nondeductible contribution to I-HOPE in the society's annual billing statement.

# Scientific Exhibits

## RICHARD B. HOVDA, M.D., *Evansville, Chairman*

### NOCTURNAL ANGINA PECTORIS — SIGNIFICANCE?

**Exhibitor:** Arthur H. Griep, M.D., Evansville

**Attendants:** Arthur H. Griep, M.D., Mrs. Jean DeJong, R.N.

The exhibit will emphasize the following points:

(1) Possible causal mechanisms of nocturnal angina pectoris in various forms of heart disease.
(2) The clinical implications of nocturnal angina pectoris.
(3) The probable importance of nocturnal angina pectoris in the prognosis of ischemic heart disease.
(4) The importance of nocturnal angina pectoris in certain forms of valvular heart disease.

### CLOACOGENIC ANORECTAL CARCINOMA

**Exhibitor:** Edwin E. Pontius, M.D., Methodist Hospital Graduate Center, Indianapolis

**Co-exhibitors:** P. Kent Cullen, M.D., Indianapolis, John Sanders, M.D., Methodist Hospital Graduate Center, Indianapolis

**Attendants:** Exhibitors as mentioned above

The cloacogenic zone of the rectum serves as origin for most anorectal cancers which reflect its histologic patterns. Twenty-three patients diagnosed and treated over a ten-year period have been studied to provide data concerning pathologic type, growth patterns and factors influencing effect of therapy.

### AMA OCCUPATIONAL HEALTH EXHIBIT

**Exhibitor:** Henry F. Howe, M.D., Director, Dept. of Occupational Health, American Medical Association, Chicago

**Co-exhibitors:** Mr. Lee N. Hames, Mr. Jerome T. Siedlecki, Chicago

**Attendants:** Exhibitors as mentioned above

Because of the nature of this joint meeting, this exhibit has been planned as an occupational health information center which would be of interest especially to the vast majority of physicians who *are not* in the full-time practice of occupational medicine. It will be manned continuously, and supplies of literature will be available without charge or can be ordered by those who do not wish to carry it. The three major sections of this occupational health center would consist of:

I. *"Physician Relationships in Occupational Medicine"*

This attractive, colorful exhibit discusses areas in which the family physician and the plant physician can and should cooperate; namely, rehabilitation, absenteeism, job placement, illness and injury reports, professional and medical society relations. It attempts to create better understanding and liaison between the physician in occupational health, especially the man doing small plant work on a part-time basis and his fellow physicians in general practice.

II. *Occupational Health Publications*

This attractive exhibit displays all of the occupational health publications which physicians can obtain without charge from the AMA Department of Occupational Health. As part of this exhibit some of the most popular publications are available for distribution on the spot and order blanks are available for those which are not.

III. *"Small Industry: An Opportunity for the Family Physician"*

This exhibit acquaints the family physician with the different types of small plant health programs, and the part he can play in them. These programs range from very small operations in which the physician devotes only a small percentage of his time, to those in which he visits a plant on a frequent regular schedule. The exhibit tells how he can do a better job of caring for his working patient.

### PRACTICAL TREATMENT OF MUSCULOSKELETAL DISORDERS

**Exhibitor:** Fred J. Phillips, M.D., Quakertown, Pennsylvania

**Co-exhibitors:** C. L. Chai, M.D., M. D. De Buque, M.D., David M. Shoemaker, M.D., Quakertown, Pa.

**Attendant:** Fred J. Phillips, M.D.

The combination of a highly soluble and potent corticoid with a local anesthetic has gained widespread acceptance in treatment of acute articular inflammatory conditions. Recently, local administration of this combination has demonstrated unusual efficacy in treatment of nonarticular musculoskeletal disorders.

Evaluation of a steroid-anesthetic preparation consisting of dexamethasone 21-phosphate and lidocaine hydrochloride was undertaken by Fred J.

Phillips, M.D., of Quakertown, Pa., in 129 patients with a variety of articular and non-articular musculoskeletal disorders of varying severity and duration. The results of this study are presented in this exhibit.

Four of the 129 patients had dual disorders totaling 133 disorders. Of these, 84 were acute and 49 were chronic disorders. The goal was the rapid relief of pain following injury and promotion of lasting symptomatic relief. Good to excellent response was yielded in 85% of the cases; moderate response in nine percent; poor or no response in the remainder. Toxic effect attributable to the medication or persistent local discomfort was not observed in any of the patients treated.

From this study it would appear that the greatest benefit derived from this preparation may be in the treatment of certain acute articular and a variety of nonarticular musculoskeletal disorders for the immediate relief of painful and disabling symptoms to help speed the patient's return to normal activities. It would also appear to be advantageous in cases where systematic corticosteroid therapy is contraindicated. With this preparation, splints and other immobilizing devices which may prolong loss of worktime were definitely not found necessary.

## RADIOACTIVE BRAIN SCANNING

**Exhibitor:** John Mealey, Jr., M.D., Indianapolis

**Co-exhibitors:** F. Mishkin, M.D., I. C. Reese, M.S., J. A. Campbell, M.D.

**Attendants:** Exhibitors as mentioned above

Brain scanning has evolved from semi-investigative status limited to relatively few institutions to a well established position in clinical practice as a safe and informative neurodiagnostic procedure. Newer radioactive agents and development of commercially available, fully automatic and multipurpose scanners have improved the results and led to more widespread use of this test.

Over 500 patients with suspected intracranial lesions were scanned at Indiana University Medical Center in the past three years. Simultaneous print-out records and photoscans were obtained. Radioactive mercury (Neohydrin $Hg^{203}$) or serum albumin ($I^{131}$) were used. Over 75% of the brain tumors in this series were correctly localized by scanning. Positive scans were seen in patients with intracranial hematomas, abscesses and extensive cerebral infarctions. False positive scans were extremely uncommon. Serial brain scans have been performed to evaluate the effects of radiotherapy and chemotherapy on intracranial neoplasms.

This exhibit will illustrate the apparatus and technics used in brain scanning and show a tabulation of the overall clinical experience at this center. A group of scans showing different intracranial lesions in multiple locations will be displayed. Composite and superimposed material — scans, skull x-rays, pneumoencephalograms and angiograms — will be utilized for visual emphasis and contrast.

## FLYING PHYSICIANS ASSOCIATION

**Exhibitor:** Indiana Chapter, Flying Physicians Association

**Attendants:** M. F. McGrath, M.D., Mrs. M. F. McGrath

This is the usual exhibit for the Flying Physicians Association, including posters descriptive of the work of the association, photographs, etc. Brochures will be available to describe both the state chapter and the national organization.

## THE MANAGEMENT OF CARDIAC EDEMA

**Exhibitor:** Benjamin Rosenberg, M.D., Brooklyn, N. Y.

**Co-exhibitors:** Harold L. Mandelbaum, M.D., Richard Rubin, M.D., Brooklyn, N. Y.

**Attendant:** Benjamin Rosenberg, M.D.

The introduction of newer diuretic agents in the treatment of congestive heart failure has been beneficial, but new problems of management have been introduced.

The data in this exhibit illustrates advanced therapeutic technics employed and the opportunities for improved management of a variety of clinical conditions. Patient response charts, metabolic and electrolyte studies and descriptive text is presented in detail.

## PRINCIPLES OF PEDIATRIC PREMEDICATION

**Exhibitor:** John B. Stetson, M.D., Indiana University Medical Center, Indianapolis

**Attendant:** John B. Stetson, M.D.

Each child is different and must be treated as an individual.

An "adequately" adjusted child will have little or no reaction to the hospital experience. The "disturbed" child may have sequelae despite faultless handling.

The anesthesiologist, as well as hospital surroundings, are variables and affect the results of premedication.

Language barriers, rough handling, noisy work areas, impersonal surroundings, can all alter the effects of premedication.

Each anesthesiologist is different and desires different results from his premedication. No patient,

physician or drug is perfect. The three, two human and one chemical, must be blended together with art and sympathy for salubrious results. An attempt must be made to evaluate results objectively.

### APPLICATION OF ECHOENCEPHALOGRAPHY IN MEDICAL PRACTICE

**Exhibitors:** Arthur Hockey, M.D., Julius Goodman, M.D., Division of Neurosurgery, Indiana University Medical Center, Indianapolis

**Attendants:** Exhibitors as mentioned above

Echoencephalography is the newest addition to the armamentarium of the practitioner in diagnosing intracranial masses. By using sound waves as in sonar, shifts of the brain can be detected at the bedside with considerable accuracy and with no risk or discomfort to the patient.

Experience with echoencephalography on the neurosurgical service of the Indiana University Medical Center will be reviewed. A machine will be available for practical demonstrations.

### EVALUATION OF IMPAIRMENT

**Exhibitor:** Frederick A. Stam, Secretary, Committee on Rating of Mental and Physical Impairment, American Medical Association, Chicago

**Attendant:** Frederick A. Stam

The distinction between "impairment" and "disability" is presented. The physician's role in each is considered. A scientific method of impairment rating is demonstrated through an example of a hypertensive stroke patient. The viewer is informed that the American Medical Association has a series of guides for evaluating impairment, is given the opportunity to peruse copies of those presently available and encouraged to acquire complimentary copies of the guides needed in his practice.

### TEMPORAL BONE BANKS PROGRAM

**Exhibitor:** Temporal Bone Banks Program for Ear Research, Ralph J. McQuiston, M.D., State Chairman of the Deafness Research Foundation, Indianapolis

**Attendant:** Ralph J. McQuiston, M.D.

The exhibit consists of three panels. The first panel has a repeating slide demonstration of the removal technics. The second panel points out the anatomy of the normal temporal bone at six different levels and the final panel shows inner ear pathology.

## INDIANA STATE ASSOCIATION OF MEDICAL ASSISTANTS

## INDIANA ACADEMY OF GENERAL PRACTICE

### LYMPHOGRAPHY — INTERPRETIVE DIFFICULTIES IN 500 STUDIES

**Exhibitor:** Patrick A. Dolan, M.D., Indianapolis, Indiana

**Attendant:** Patrick A. Dolan, M.D.

Lymphography is an accurate method of assessing the status of lymph nodes in sites ordinarily inaccessible to other methods of examination. Though on occasion difficult and time-consuming, it is usually no more difficult than many of the other special radiography examinations performed in a hospital department of radiology.

More than 500 of these examinations have been performed by the author.

Though the examination is highly accurate, certain technical and interpretive difficulties arise. The latter is to be expected, since lymphatic structures can only react to disease in limited ways. Overlapping of the patterns of the various disease processes manifested in the lymph nodes may therefore be expected. This on occasion results in an erroneous specific diagnosis.

The exhibit discusses and illustrates some of the difficulties which the author has encountered in this large series.

### CAREERS IN MEDICAL TECHNOLOGY

**Exhibitor:** Indiana Society of Medical Technologists

**Co-exhibitor:** Indiana Association of Pathologists

**Attendants:** Mr. Jack D. Closson, M.T. (ASCP)
Robert L. Costin, M.D.

This exhibit consists of printed panels which demonstrate the various careers available in the medical laboratory — including those of the pathologist, the medical technologist, the laboratory assistant and the cytotechnologist.

### "DOCTOR, ARE YOU SURE YOU CAN RELY ON YOUR LABORATORY?"

**Exhibitor:** Indiana Association of Pathologists

**Attendant:** Robert L. Costin, M.D.

This exhibit consists of printed panels which clearly answer the title question — pointing out that a clinician's best safeguard is a medical laboratory directed by a physician, preferably by a pathologist, and also points out the dangers and characteristics of unreliable laboratories.

## SELECTIVE RENAL ANGIOGRAPHY

**Exhibitor:** Erich K. Lang, M.D., et al., Methodist Hospital, Indianapolis

**Co-exhibitors:** William Niles Wishard, M.D., Lawrence Allen, M.D., John Mertz, M.D., Donald McCallum, M.D., Bennie Davis, M.D., Myron Nourse, M.D., Dan Newman, M.D., William Sutton, M.D., John Klingerman, M.D.

**Attendants:** Lawrence Allen, M.D., John Klingerman, M.D.

Selective renal arteriography is used for the demonstration of intrarenal vascular lesions, abnormal vessel formations of tumors or inflammatory etiology and selective chemotherapeutic perfusion. Appropriate samples for stenotic interrenal vascular lesions, characteristic intrarenal tumors and the therapeutic application of this method are given.

## COMPREHENSIVE COMMUNITY MENTAL HEALTH CENTERS

**Exhibitor:** Indiana Department of Mental Health

**Attendants:** Robert H. Branson, Sandra S. Miller, Rosemary Lewis

The characteristics of future community mental health centers in Indiana will reflect the special needs and resources of their areas. The display illustrates general services they should offer.

Psychiatric *emergency* services
Inpatient services
Outpatient services
Partial hospital
Community service
Diagnostic services
Rehabilitation services
Training
Research and evaluation
Pre-care and after-care services

## HIATAL HERNIA COMPLEX

**Exhibitor:** J. K. Berman, M.D., et al., Medical Education, Methodist Hospital, Indianapolis

**Co-exhibitors:** E. J. Berman, M.D., A. W. Schmalhausen, M.D., John Kimble, M.D.

**Attendants:** John Kimble, M.D., James Egan, M.D.

Hiatal hernia with esophagitis is a complex disease in which the anatomical defect is but a part of the total abnormality. Therefore, repair of the hiatus alone is insufficient to produce a cure.

The "balanced" procedure (so-called for lack of a better term) is designed to bring the stomach into its normal position, reduce acid (vogotomy), repair the defect in the diaphragms, curtail regurgitation (esophagogastropexy) and facilitate gastric emptying (pyloroplasty).

Descriptions of experimental and clinical studies and results will be documented.

# Technical Exhibitors

(Letter prefix denotes aisle)

ABBOTT LABORATORIES — Booth L-5
14th and Sheridan Rd. — North Chicago, Ill.
S. D. Redman

AKRON SURGICAL HOUSE, INC. — Booths B-3 & B-5
1927 N. Capitol Ave. — Indianapolis 2, Ind.

AMERICAN FLETCHER NATIONAL BANK & TRUST CO. — Booth B-10
101 Monument Circle — Indianapolis 4, Ind.
Albert E. Metzger, Edward J. Lott, Lloyd R. Howe, James R. Stewart

AMERICANA CORPORATION — Booth B-18
(National Professional Exhibits Division)
291 S. LaCienega Blvd., Suite 303
Beverly Hills, Calif.

AMES COMPANY, INC. — Booth C-22
819 McNaughton Ave. — Elkhart, Ind.
Frederick J. Verderosa

ARNAR-STONE LABORATORIES, INC. — Booth D-1
601 East Kensington Road — Mount Prospect, Ill.
William Snider

ASTRA PHARMACEUTICAL PRODUCTS, INC. — Booth D-12
7 Neponset St. — Worcester 6, Mass.
David E. DeWine, Ingvar Jonsson

AYERST LABORATORIES — Booth B-15
7545 N. Natchez Ave. — Chicago 48, Ill.
R. J. Carroll, M. L. Gurchiek, T. J. Wise, S. A. Muir

BAKER BROTHERS, INC. — Booths C-24 & C-26
2039 N. Capitol Ave. — Indianapolis 2, Ind.
Frank M. Jones, Mrs. Frank M. Jones, Terry Jones, Tom Jones

BIO-DYNAMICS, INC. — Booth D-8
3513 N. Hovey St. — Indianapolis 18, Ind.
Ray Kiess, Bill Eason, Joe Borders, Paul LaHue

BLACK & SKAGGS ASSOCIATES, INC. — Booth L-7
(Professional Management)
181 North Ave. — Battle Creek, Mich.
Harold L. Neff, Paul D. Evans

BRIAR PHARMACEUTICAL, INC. — Booth A-12
54 Briar Rd. — Golf, Ill.
Forrest W. Willis, Mary F. Willis

BRISTOL LABORATORIES — Booth D-15
P. O. Box 657 — Syracuse 1, N. Y.
C. F. Magers, J. R. Zickgraf, P. W. Strom, J. M. Hansen, R. H. Thayer

BROILITIZER SALES — Booth A-18
Western Division
850 N. Virgil Ave. — Los Angeles 29, Calif.
Ernest Lieblich

BURROUGHS WELLCOME & CO., (U.S.A.) INC. — Booth D-3
1 Scarsdale Rd. — Tuckahoe 7, N.Y.
J. M. Brown, R. C. Delagrange, J. R. Borgmann, J. R. Whitehead

CARNATION COMPANY — Booth C-12
Carnation Bldg., 5045 Wilshire Blvd.
Los Angeles 36, Calif.
Clifford L. Schultz

CENTRAL BRACE AND LIMB COMPANY — Booth C-23
1618 N. Illinois St. — Indianapolis, Ind.
Kermit K. Taylor, Miles A. Hobbs, Jack Milbourn

CIBA PHARMACEUTICAL COMPANY — Booth D-20
556 Morris Ave. — Summit, N. J.

THE COCA-COLA COMPANY — Booth B-25
P. O. Drawer 1734, 310 North Ave., N.W.
Atlanta 1, Ga.

CONTOUR SALES, INC. — Booths B-11 & B-13
3728 E. 38th St. — Indianapolis, Ind.
Ed Olin, Bertie Bewley, Virginia Schell

CURTIS AND FRENCH, INC. — Booth C-6
444 W. 16th St. — Indianapolis 2, Ind.
D. F. Curtis, C. E. McCain, Don Graves

DAIRY COUNCILS OF INDIANA — Booth D-30
50 S. Parker Ave. — Indianapolis 1, Ind.
Mrs. Barbara T. Morley, Mrs. Nancy Leedy, Mrs. Hazel Burnett, Mrs. Lillian E. Staub, Mrs. Lois Smith

DOME CHEMICALS, INC. — Booth A-14
125 W. End Ave. — New York 23, N. Y.
Robert Swift, Justin Rockwood

D. M. DOYLE PHARMACEUTICAL COMPANY — Booth D-19
A Division of the Dietene Company
Highway 100 at W. 23rd St.
Minneapolis 16, Minn.
Bernie Naber, Gary Gallagher

ENCYCLOPAEDIA BRITTANICA, INC. Booth D-10
425 N. Michigan Ave. Chicago 11, Ill.

MARSHALL ERDMAN AND ASSOCIATES, INC. Booth L-9
5117 University Ave. Madison 5, Wis.
Don Brickson, Hi Walker

FLINT LABORATORIES Booth C-3
Division of Baxter Laboratories, Inc.
6301 Lincoln Avenue Morton Grove, Ill.
James Haiz, R. Randle

GEIGY PHARMACEUTICALS Booth B-4
P. O. Box 430 Yonkers, N. Y.

GERBER PRODUCTS COMPANY Booth C-1
445 State St. Fremont, Mich.
Derrick Harris, Joe Madigan

GREAT BOOKS OF THE WESTERN WORLD Booth C-5
425 N. Michigan Ave. Chicago 11, Ill.
Jack B. Follis

HEID'S HEALTH-SHOE STORE Booth B-21
411 N. Illinois St. Indianapolis, Ind.
Irvin F. Heidenreich, Hubert J. Heidenreich

HEWLETT PACKARD COMPANY Booth B-16
Sanborn Division
Waltham, Mass.
David M. Beveridge, William Hackett, R. Arbuckle

HOOK DRUGS, INC. Booth A-20
2800 Enterprise Indianapolis, Ind.
James M. Rogers

INDIANA BELL TELEPHONE COMPANY Booth D-17
240 N. Meridian St., Room 1207 Indianapolis, Ind.

INDIANA BRACE SHOP, INC. Booth B-24
72 W. New York St. Indianapolis 4, Ind.

INDIANA NATIONAL BANK Booth L-3
3 Virginia Ave. Indianapolis 9, Ind.
Howard A. Pelham, J. Peter Frenzell III, John Weissert, William Myers, Robert Whitaker, Grover Archer, Thomas Frank, Carroll Moore, Donald Cermack, Jean Thoman, Harry Sommer, William Knowles

INDIANA SURGICAL, INC. Booth B-23
5541 E. Washington St. Indianapolis 19, Ind.

LEDERLE LABORATORIES Booth C-15
Pearl River, New York

ELI LILLY AND COMPANY Booth B-2
P. O. Box 618 Indianapolis 6, Ind.
H. O. Johnson, N. L. Stephenson, P. A. Holsapple, L. L. Neel, R. N. Thomas, E. E. Colville, P. H. Feucht

J. B. LIPPINCOTT COMPANY Booth L-6
East Washington Square Philadelphia 5, Pa.
Marvin T. Secord, William G. Simpson

LOMA LINDA FOOD COMPANY Booth C-9
Riverside, California

P. LORILLARD COMPANY Booth D-22
200 E. 42nd St. New York 17, N. Y.
M. L. Baker, R. E. Larry

MARION LABORATORIES, INC. Booth D-18
4500 E. 75th Terrace, P. O. Box 963
Kansas City 32, Mo.
Howard Murray, Alan Cushing

McNEIL LABORATORIES, INC. Booth C-18
Camp Hill Rd. Fort Washington, Pa.
Charles T. Love, Wilbur Dollens, James Lang, Jack O'Brien

MEAD JOHNSON LABORATORIES Booth D-7
Evansville, Ind.

MEDCO PRODUCTS COMPANY, INC. Booth D-23
3601 E. Admiral Pl., P.O. Box 3338, Tulsa 12, Okla.
Jim Shores, Charles Crafton, W. W. Kyle

THE MEDICAL PROTECTIVE COMPANY Booth B-6
Station "A", Box 2021, 5814 Reed Rd.
Fort Wayne, Ind.
Kenneth W. Moeller and David A. Rogers

MERCK SHARP & DOHME Booth D-21
West Point, Pa.
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# Indiana University Medical Center Tour

Buses for the medical center tour will leave the Murat Temple at 15-minute intervals from 8:30 until 11:30 a.m. on Wednesday, Oct. 13. The buses will make a loop through the medical center, stopping at stations at Emerson Hall, the Medical Science Building, Riley Hospital, the Institute of Psychiatric Research, Marion County General Hospital and the Veterans Administration Hospital, in that order. After the last stop they will return to the Murat Temple.

Those taking the tour may stop at any station they wish, where they will be shown areas of interest by faculty members and students. They may then take the next bus to any other station. Maps of the campus and the various stations will be available on the bus. Some are within easy walking distance of one another.

Brief summaries of the demonstrations to be presented at the various stations follow:

EMERSON HALL:

**Department of Medicine** — *Pulmonary Function Testing*

The pulmonary test facilities of the Department of Medicine are well equipped and heavily used for clinical testing and research in abnormal physiology. Demonstrations will include ventilation and lung volume measurements by spirometry, use of the body plethysmograph for determining residual lung volume and air-way resistance, pulmonary diffusing capacity measurements, observation of regional ventilation and blood flow with $Xenon^{133}$ and standard blood gas measurement technics.

**Department of Surgery** — *Implantable Mechanical Heart*

This demonstration will outline the design and fabrication of an implantable mechanical heart. Animal experiments with it will be described and systemic and pulmonary arterial pressure tracings will be shown. The heart is activated through a fluid system by a small electromotor pump. Plans for further re-refinement and testing of this device will be presented.

MEDICAL SCIENCE BUILDING

Tours of this building will survey some of the important facilities employed for instruction of medical and graduate students in the pre-clinical sciences through the departments of anatomy, microbiology, pharmacology, biochemistry and pathology. In addition to the lecture rooms, student laboratories and library, certain key research laboratories will be visited, including the electron microscope facility, the microbiology virus laboratory and media room and the toxicology laboratory.

JAMES WHITCOMB RILEY HOSPITAL FOR CHILDREN

**Department of Pediatrics**

The Department of Pediatrics is concerned with the usual combination of teaching, research and patient care. Clinical clerkships are provided for both junior and senior medical students. They work closely with the interns and residents in the care of patients and attend the regular ward rounds with the staff. Most of the work is done in Riley Hospital where the patients have usually been referred because they present difficult and unusual problems. Tours of the hospital will be arranged for visitors, particularly of the new Hanley addition.

INSTITUTE OF PSYCHIATRIC RESEARCH

The Institute of Psychiatric Research is the state's only facility

devoted to full-time investigative work in the area of mental health. Now recognized as one of the most outstanding institutions of its kind in the United States, it is visited regularly by mental health and research administrative and planning officials from all over the United States as a prototype for such facilities elsewhere. Ongoing projects include investigation in the basic sciences and clinical phenomena related to human and infrahuman psychological and social functioning.

MARION COUNTY GENERAL HOSPITAL

**Eli Lilly Clinical Research Unit**

This area will be of interest to those who wish to visit a modern metabolic unit with associated laboratories in which clinical pharmacology is performed. This is located in the west wing of the Marion County General Hospital.

**Krannert Heart Research Institute**

Interesting and important research is being carried on in the Krannert Heart Research Institute, which is housed in a new wing to the west of General Hospital's Flower Mission annex. Two specific areas of research to be demonstrated there include:

Experimental studies being pursued in the use of isotope Rubidium 84 in determining coronary blood flow. The isotope is infused intravenously and the myocardial uptake of the isotope is counted by means of scintillation crystals placed anterior and posterior to the heart. The brachial arterial blood is also monitored and by use of this data, coronary blood flow is determined.

Modern electrophysiology is a research discipline which permits the investigation of the electrical properties of cardiac tissue. Utilizing micro-glass electrodes, the potential differences of individual cells are recorded in vitro. Thus the mechanism of arrhythmias, as well as drug action relative to electrolyte metabolism, may be explored and enable the physician to treat cardiac disease with a more comprehensive grasp of available therapy.

**Physical Medicine and Rehabilitation**

Facilities for diagnosis and treatment in this new unit at Marion County General Hospital will be available for inspection.

VETERANS ADMINISTRATION HOSPITAL

At this station, visitors will have the opportunity of touring an important institution on the medical school campus. There will be a demonstration in the field of gastroenterology using new technics of gastroscopy.

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# DECISIONS AND OPINIONS

**Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.**

*Court's ordering of Blood Transfusion for Adult over Religious Objections Unconstitutional*—An order of a trial court appointing a conservator for an adult hospital patient who had, because of her religious convictions, refused to receive a blood transfusion and authorizing the conservator to consent to transfusions for the patient was unconstitutional, the Illinois Supreme Court ruled.

The patient suffered from a peptic ulcer. She had repeatedly told her doctor during the two years that he had treated her prior to her hospitalization that her religious convictions, as a Jehovah's Witness, precluded her from receiving blood transfusions. After the patient and her husband signed documents releasing both the doctor and the hospital from all civil liability that might result from the failure to administer blood transfusions to her, they were assured that no further efforts would be made to persuade her to accept blood. Despite these assurances, the doctor and the State's Attorney applied for an order appointing a conservator for the patient and authorizing the conservator to consent to transfusions for her. The order was granted and a transfusion administered.

It was contended that since the transfusion had been given, the conservator discharged, and the estate closed, the case was moot. Although the general rule is that a case that has become moot will be dismissed on appeal, an exception is made when the issue presented is of substantial public interest. This case, involving as it does the relation between governmental action and the religious beliefs of individual citizens, came within the exception, the court said.

It was argued that society had an overriding interest in protecting its citizens' lives which justified the action taken. The cases cited in support of the argument—those involving compulsory vaccination, polygamy, snake handling in religious rituals and court-ordered transfusions for minors—were not applicable, the court said. Nor were the decisions in the two cases in which transfusions were ordered for adults over their religious objections, *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (*The Citation*, Vol. 8, No. 7, p. 53; Vol. 9, No. 3, p. 33), *and Raleigh Fitkin-Paul Morgan Memorial Foundation v. Anderson*, 201 A.2d 537 (*The Citation*, Vol. 10, No. 1, p. 20), determinative of the issue presented here. In the *Georgetown* case, the patient was the mother of several small children, and she and her husband, although they said the transfusion would be against their will, intimated that the court could take the matter out of their hands. In the *Raleigh-Fitkin* case, the patient was pregnant and the court held that it was unnecessary to decide whether the patient could have been compelled to accept a transfusion if only her life had been at stake. No minor children were involved in the present case.

The First Amendment as extended to the states by the Fourteenth Amendment protects every individual's absolute right to freedom of religious belief and the exercise thereof, except that the exercise thereof may be limited by governmental action if it constitutes a clear and present danger to the public health, welfare, or morals. No act of the patient presents any clear and present danger to society. What was done here was a judicial attempt to decide what course of action was best for the patient, despite


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her contrary views based on religious convictions. Such action was clearly unconstitutional, the court said.

*In re Brooks' Estate*, 205 N.E.2d 435 (Ill., March 18, 1965).

*Citation Editor's Note*: The trial court decision in this case was reported in *The Citation*, Vol. 9, No. 10, p. 170.

*Transfusion Ordered for Child over Parents' Religious Objection*—An order authorizing a blood transfusion for a 23-month-old boy was issued by a probate court, despite the objection of his parents that receiving a blood transfusion was contrary to their religious beliefs as Jehovah's Witnesses. Doctors testified that the child, who suffers from acute hemolytic anemia, would probably not live through the day without a transfusion. It was reported that the child was still in serious condition, but out of immediate danger, after the transfusion. (News Release, Chicago, Ill., April 21 and 22, 1965.)

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*Physician Has Duty to Warn of Pyribenzamine's Side-effects*—In a suit by a bus passenger for damage sustained in an accident when the bus driver, who had taken Pyribenzamine, fell asleep, there was sufficient evidence to sustain a jury finding that the physician who prescribed the drug was negligent in having failed to warn the driver of its possible side-effects, and that that negligence was the proximate cause of the passenger's injuries, the Washington Supreme Court ruled. A judgment in favor of the physician was reversed and the case remanded for a new trial.

The physician prescribed Pyribenzamine for the driver's nasal condition. The driver testified that the physician gave him no warning of any possible side-effects of the drug. He took the first pill the morning of the accident. He felt groggy and drowsy a few miles before the accident and his lips and tongue were dry. The driver fell asleep or blacked out shortly before the bus left the road.

Several physicians testified that the standard of practice in the community required a physician to warn a patient for whom he prescribed Pyribenzamine of its possible side-effects since about 20% of those taking the drug experience them. This evidence, together with the driver's testimony that the physician had given him no warning, was sufficient to raise a jury question as to the physician's negligence.

The physician contended that even if he was negligent, his negligence was not the proximate cause of the accident because of the driver's intervening negligence in continuing to drive the bus after he became drowsy. The causal connection between a person's negligence and an injury is broken by the intervention of an independent negligent act only if the intervening act was not reasonably foreseeable. The driver, who was suddenly stricken by the unforeseen loss of consciousness, was not chargeable with negligence. In falling asleep or blacking out, the driver was not negligent, as a matter of law, despite the premonitory symptoms he experienced, the court said. This conclusion was strengthened by testimony that the drug affected his judgment.

It could not be said that the driver had

violated the statute making it a crime for a person to drive when he is under the influence of any drug to the extent that he is incapable of driving safely, and that he was therefore negligent as a matter of law. A person who drove after innocently taking a pill prescribed by a doctor without knowledge of its harmful qualities could not be convicted under the statute and could not be held to be negligent per se, the court said.

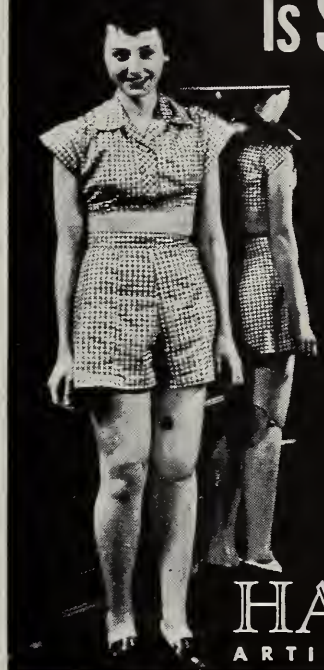
One judge dissented with respect to the driver's negligence. He said that, in view of the many drugs known to produce drowsiness in varying degrees taken today by millions of people, it should be held that a person who drives after knowingly taking a drug could violate the statute prohibiting driving while under the influence of drugs and would be negligent per se.

*Kaiser v. Suburban Transportation System*, 398 P. 2d 14 (Wash., Jan. 7, 1965).

*Physician Liable for Patient's Death from Cardiac Arrest During Surgery*—The husband of a patient was entitled to recover damages in a suit against a physician for her death from cardiac arrest during sur-

Continued


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gery. The evidence was sufficient to support a finding that the physician was negligent in proceeding with the surgery after the patient had had an asthmatic attack several hours before and that this negligence was the proximate cause of her death, a Michigan intermediate appellate court ruled.

The patient suffered a five-hour asthmatic attack the night before she was scheduled to undergo elective abdominal surgery. Three hours after the attack had been brought under control, the physician began the operation as scheduled. The patient suffered a sudden cardiac arrest during the operation from which she died within a short time.

A medical expert who testified for the husband stated that, in his opinion, the physician failed to adhere to the standard of practice for physicians in the community which required a physician to delay surgery until such time as the patient had recuperated from the asthmatic attack. He also stated that the physician's failure to adhere to this standard of practice could have caused the cardiac arrest. Two medical experts for the physician testified that the community standard of practice did not require him to delay the operation, and that the cardiac arrest could have been brought about by many causes.

This conflict in the testimony of qualified expert witnesses raised an issue of fact to be resolved by the trier of the facts. The trial court, sitting without a jury, made a finding that the physician was negligent and that his negligence was the proximate cause of the patient's death. Since the evidence did not clearly preponderate in the opposite direction, this finding could not be disturbed, the court said.

*Bradshaw v. Blaine,* 134 N.W.2d 386 (Mich., April 19, 1965).

*Physician Not Liable for Cancer Death Despite Temporary Loss of Sponges*—A jury returned a verdict in favor of a physician in a suit against him for damages for the death from cancer of a patient on whom




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the physician had performed two abdominal operations. In the first operation, a sponge was lost for a short time but was recovered in the second phase of the operation. A second operation was performed a few days later when gangrene developed. A sponge lost in this operation was recovered two weeks later when the wound was irrigated. The patient was discharged from the hospital the next week. He died more than three years later.

*Campbell v. Orndorff*, Cir. Ct., Cook Co., Docket No. 58C-8763 (Ill., May 13, 1965).

*Fluoridation of City Water Upheld*—A provision of the New York City Health Code authorizing the fluoridation of the city's water supply was valid, a New York trial court ruled.

The New York City Board of Health has the power to enact provisions for the furtherance and protection of health, and its enactments have within the city the force and effect of state law. The fluoridation program was obviously an attempt to cope with the public health problem of tooth decay and dental neglect, particularly among children. The most that can be said against the program is that there is a doubt as to the value of fluoridation and that it may not be the best way of attacking the problem. The code's authorization of fluoridation was not contrary to any state public policy or to any existing state statute or municipal ordinance, and it was not in excess of the health department's power.

The expenditure of funds from the expense budget was authorized for the purchase and installation of the necessary facilities and equipment for fluoridation. It was claimed that this was illegal and that the proper method of appropriating funds for the program was by an amendment to the city's capital budget. The charter provisions with respect to the capital budget apply only when the city is going to borrow money to provide for a capital project. There was nothing indicating that any money was going to be borrowed to finance the fluoridation program.

It was contended that the fluoridation program violated the privileges and immunities, equal protection, and due process clauses of the state and federal constitutions in that: (1) other methods of reducing tooth decay are available; (2) fluoridation is discriminatory in that it benefits children only; (3) fluoridation unlawfully imposes medication on people against their will; (4) fluoridation "is or may be" dangerous to health.

It was not relevant that other means of reducing tooth decay were available, the court said. The only question is whether fluoridation is a lawful means of attacking the problem.

There was no merit to the claim that fluoridation was discriminatory because it benefits only children. Children ultimately become adults and fluoridation will ultimately affect all.

The program was not an unlawful restriction on the liberty of individuals. Individual liberty may lawfully be restrained by legislation, the basic purpose of which is to promote public health. Different considerations might be present if the condition attacked was in the nature of an "adult" disease. It was clearly not unreasonable for the state, acting in the interest of its children, too young to be sui juris, to intervene in the parental area, the court said.

The scientific evidence as to the harmful effects of fluoridation is now in a purely speculative state. Until some proof is adduced that fluoridation has harmful side-effects, a court does not have the power to set aside the decision of the legislative or

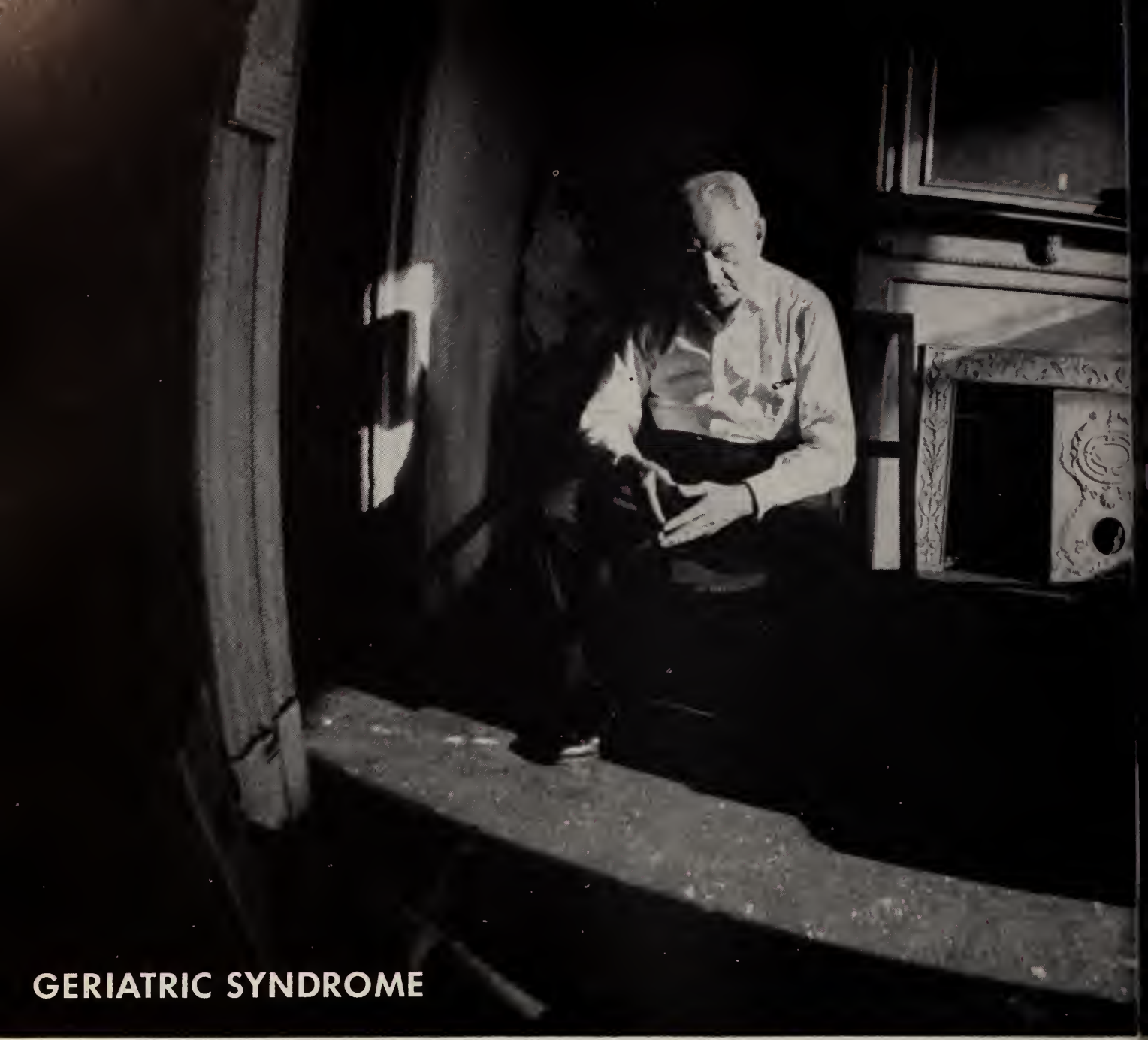
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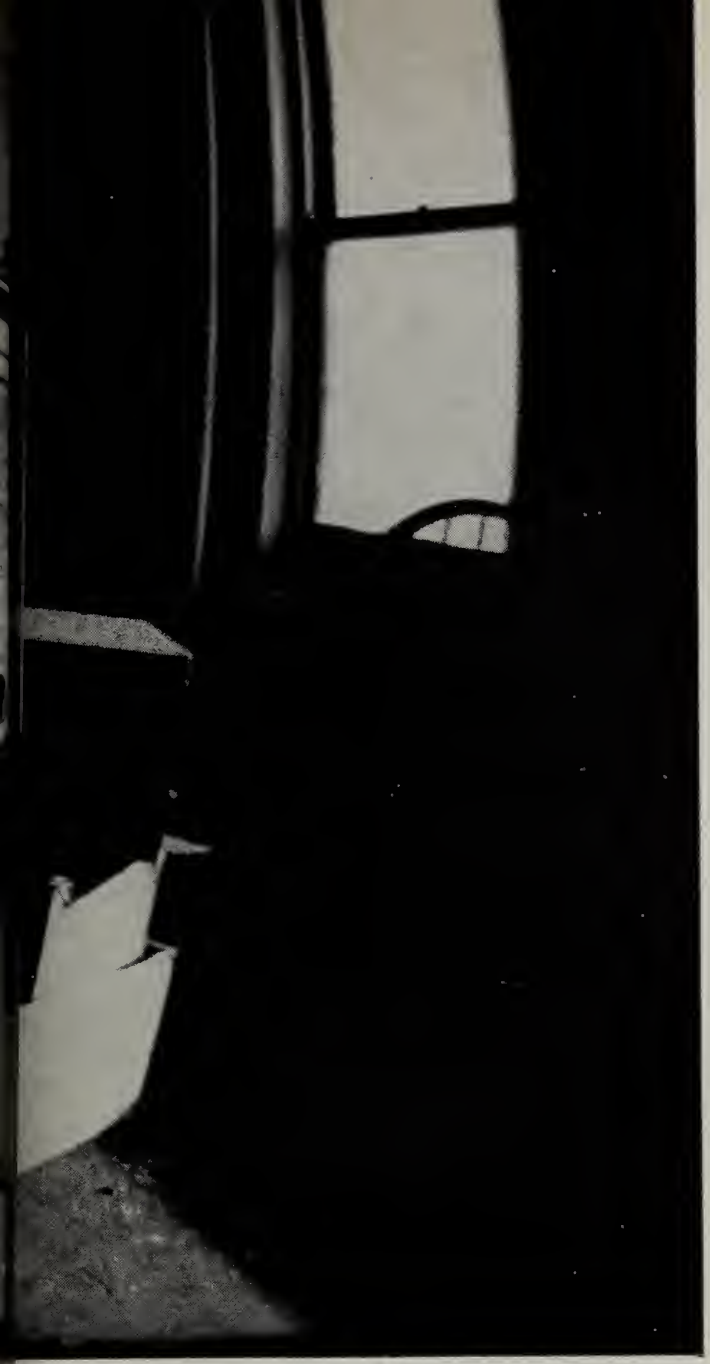
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Continued

the executive branch to fluoridate a water supply.

*Paduano v. City of New York,* 257 N.Y. S. 2d 531 (N.Y., Feb. 15, 1965).

*Hospital Liable for Patient's Fall*—A patient was entitled to recover damages in a suit against a hospital for injuries sustained when she fell while trying to get out of bed unassisted, a Florida appellate court ruled. The evidence was sufficient to support the jury's finding that the fall was proximately caused by the hospital's negligence in failing to put up the bed rails.

The patient was suffering from pheochromocytoma, a disorder which causes dizziness, headaches and instability. Her physician had instructed the hospital that she was to have bed rest. The hospital did not tell the patient to call for assistance if she had to go to the bathroom, or that she was not to get out of bed without assistance. When she awoke very early in the morning because of an urgent need to void, she did not call for assistance. She got out of her bed, on which the side rails were not up, and after taking a few steps fell, either because of dizziness or a slip.

A hospital is required to use the degree of care toward a patient that is reasonable in light of the patient's known condition and the degree of care used by hospitals generally in the community. There was evidence that the general nursing practice in the community was to put up bed rails for patients over 60 to deter them from leaving their beds. This evidence, together with the hospital's knowledge of the patient's disorder and her physician's instructions as to bed rest, was sufficient to support the jury's finding that the hospital was negligent in not putting the bed rails up on her bed. The jury's findings that this negligence was the proximate cause of the patient's fall and that she was not contributorily negligent were also supported by the evidence, the court said.

*Mercy Hospital, Inc. v. Larkins,* 174 So. 2d 408 (Fla., April 27, 1965). ◄

# Three Years With Resolution #26 (2)

*(One of a series prepared by Blue Shield)*

*(This article concludes the presentation made at the 1965 Blue Shield Seminar by Lowell I. Thomas, M.D., Indianapolis, Chairman of the Marion County Medical Society's Insurance Committee.)*

Why has the no fee schedule plan worked well? I believe the main reason is the desire of Indiana physicians wanting it to work. This plan involves the payment of several million dollars annually in indemnities, yet in three and one half years of operation, our county review committee has been asked to review only two claims the first year, two claims the second year, one the third year and, so far, none this year. The fact that the plan can remain solvent under the no indemnity schedule and continue paying "usual and customary" fees in full shows that physicians are *not* inclined to price the plan out of the market as some felt we would do.

Most doctors understand that insurance does not create new money, and that it cannot withstand increased cost simply because the money is pooled. Most physicians recognize that prepaid insurance has greatly improved collections, and they want this stabilizing force to remain effective. The gift of your time and efforts here today and on behalf of Blue Shield in your community explains why this plan has worked well.

How does the review committee function? This plan is a sort of free-floating mechanism that could easily sail away out of control if we did not stay mindful of certain guide lines.

1. The County Review Committee serves a function of communication between the insurance company, physicians, and patients. We try through discussions to reconcile medical pricing practices with those mystical words "usual," "customary," "prevailing," "necessary" and "reasonable." These are the words most commonly used in contracts, but who can define them understandably to anyone but himself?

2. Ours is not a grievance committee. The setting of a fee for services to be rendered is an implied contract between a physician and a patient and the committee in no way questions this agreement.

3. The committee concerns itself only with respect to the insurance company's responsibility.

4. We make no attempt to relate the fee to quality of care, nor do we imply any disciplinary action. We look upon our function as advisory in nature, standing ready to serve the insurance industry, physicians and patients in respect to professional advice on insurance dollar allowances we believe should prevail in Marion County.

Through the "no fee schedule" plan, Blue Shield has been able to revise dollar allowances without having to wait for revisions of a printed schedule. Professional services not adequately covered in the past can now receive better coverage promptly. This has been most noticeable in coverage for medical services, and in covering brand new procedures and technics as they become frequently used.

We feel that in three and one half years of state-wide experience, the no fee schedule county option plan is giving the most comprehensive coverage Blue Shield has to offer. It is a changing plan with controls that make it responsive to local needs in each community.

We believe Indiana Blue Shield is capable and ready to show the influence physicians want to exert in the area of prepaid health insurance. ◄

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# ABSTRACTS

## BOOK REVIEWS

### CURRENT THERAPY, 1965

*Edited by Howard F. Conn*, W. B. Saunders Co., Philadelphia, 801 pages, $13.00.

As I look upon my review of last year's edition, I find myself at a loss as to what to say that has not been said before.

However, I do raise a very modest query. Spot checking many new contributions, it is my opinion that not all replacements are improvements, per se. Granting the fact of the dizzy pace of changing therapies—is a *yearly* edition really necessary? Why not every odd (or even) year? Or do we have to follow the fashions set by the automobile producers?

In any case, the edition continues the superb pace that has become traditional. The publisher does his part: now it is up to the reader to thumb his way through the current issue to obtain the dernier cri answers.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

Abstracts From Various Literature, Prepared by AMA

### BENIGN POLYCYTHEMIA: GAISBOCK'S SYNDROME

R. Russell and C. L. Conley (Johns Hopkins Hosp., Baltimore)

*Arch. Intern. Med.* 114:734 (Dec.), 1964.

In a survey of 6,000 consecutive patients in a general hospital, 67 had hematocrit values of 54% or higher. When patients with dehydration and arterial oxygen unsaturation were excluded, the most common cause of a high hematocrit value was a benign form of polycythemia resembling Gaisbock's syndrome. An analysis of 25 cases of benign polycythemia revealed a high frequency of stocky body build, plethoric appearance, anxiety-tension state, hypertension and vascular disease. The multiple features of the syndrome appeared to be constitutional and of familial occurrence. The benign nature of the polycythemia was established by the long follow-up in some cases. Whether or not venesections are beneficial to patients with this syndrome have not yet been established.

### THE INCIDENCE OF THROMBOEMBOLISM IN ENOVID USERS

I. C. Winter

*Metabolism* 14:422-428, (March, pt. 2), 1965.

Comparison of the reported fatalities from idiopathic thromboembolism in norethynodrel with mestranol (Enovid) users with that predicted from the population at risk in the years 1961 and 1963 supports the conclusion of the Wright Com-

Continued

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Continued

mittee, based on the single year 1962, that "no significant increase in the risk of thromboembolic death from the use of Enovid has been demonstrated." Despite the difficulties of estimating such extremely low incidence rates, it is apparent that massive use of norethynodrel with mestranol has not increased the incidence of thromboembolic disease in women.

## SUSTAINED PALLIATION IN OVARIAN CARCINOMA

T. B. Lebherz et al. (U.S. Naval Hosp., San Diego, Calif.).

*Obstet. Gynec.* 25:475, (April), 1965.

Chlorambucil was used in the management of advanced ovarian carcinoma in 85 patients. Salvage time in months suggests that this drug is at least as effective as irradiation. The drug was successful in 65% of the patients as evidenced by objective and subjective response for nine or more months. Dosage consists of 0.3/mg/kg/24 hours for 28 days, followed by continuous maintenance therapy in that amount of drug necessary to produce a leukopenia of 3,500 to 5,000 white blood cells. Severe leukopenia developed in three patients; all responded to steroid corrective treatment. Average salvage time in months with chlorambucil treatment was 20.0 months compared to an average of 15.5 months with irradiation.

## CLINICALLY SIGNIFICANT ENDOMETRIOSIS OF THE URINARY TRACT

K. E. Stanley, Jr., D. C. Utz, M. B. Dockerty (Mayo Clinic, Rochester, Minn.)

*Surg. Gynec. Obstet.* 120:491, (March), 1965.

This report comprises a study of all patients with endometriosis of the urinary tract seen at the Mayo Clinic between 1920 and 1961. Small endometriomas which neither produced symptoms nor required treatment were not included. As a result of this detailed review, 19 patients were studied: 10 with bladder involvement, six with endometriotic obstruction of the ureter and three with involvement of both the bladder and the terminal portions of the ureter, endometriosis of the ureterovesical juncture. Suprapubic pain related to bladder distension or urination or both was the most common symptom of endometriosis of the bladder. The treatment was surgical. A course of roentgen therapy to the remaining ovary produced complete and permanent relief of the symptoms. Malignant transformation of a vesical endometrioma has not yet been documented.

## LIFE WITHOUT A PANCREAS

A. G. W. Whitfield et al. (The Medical School, Birmingham, England)

*Lancet* 1:675, (March 27), 1965.

The authors report observations on a patient whose whole pancreas was removed over 15 years

Continued

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# ABSTRACTS

Continued

ago and who is still alive and reasonably well. His diabetes is controlled by 22-30 units of insulin daily. Insulin reactions have not been a feature. The only diabetic complication is absence of the knee and ankle jerks. Histology of his liver is normal apart from large amounts of lipid throughout the lobules. There is no iron deposition. His serum-amylase is 20 units per 100 ml and his serum calcium and phosphorus and skeletal roentgenographs are normal. Fecal fat and nitrogen loss is appreciably reduced by 12 gm of pancreatin daily and with this medication body-weight is maintained.

## THE ACUTE EFFECT OF CIGARETTE SMOKING ON PULMONARY FUNCTION

T. T. Chapman (Baggot Street Hosp., Dublin) *J. Irish Med. Assoc.* 56:72-74, (March), 1965.

Six patients suffering from chronic nonspecific lung disease with pulmonary insufficiency at rest, were examined before and after smoking a cigarette. In four of the patients, the arterial oxygen saturation showed a significant drop. In twelve volunteers, who had a diffusing capacity estimated before and after smoking a cigarette, there was a constant fall in value after smoking. These results suggest that cigarette smoking has an acute effect on the pulmonary vasculature, causing a diminution in the circulation.

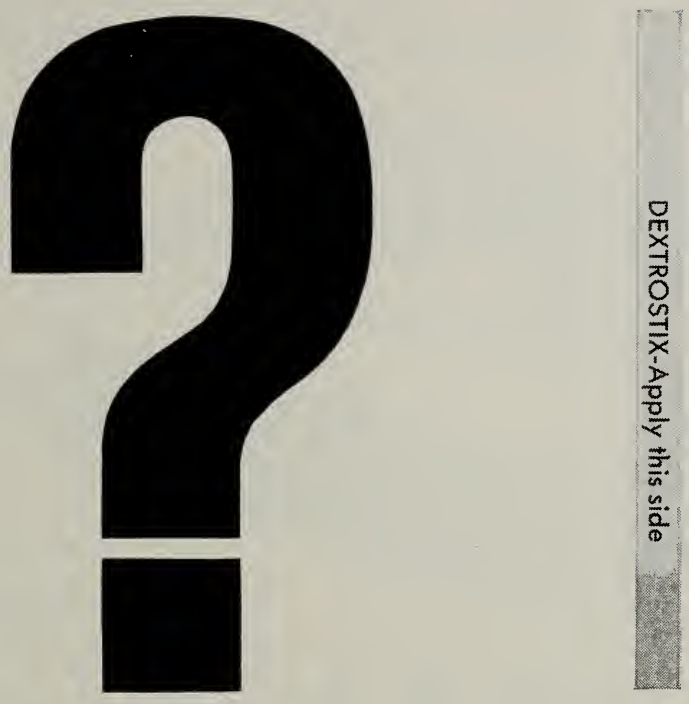
## CLOSED-CHEST CARDIAC RESUSCITATION IN PATIENTS WITH ACUTE MYOCARDIAL INFARCTION

M. M. Nachlas (Sinai Hosp. of Baltimore, Inc., Baltimore) and D. I. Miller

*Amer. Heart. J.* 69:448-459, (April), 1965.

An experience with 60 patients who sustained cardiac arrest while convalescing from acute myocardial infarction has been described. Eighty-three percent of the patients sustained their arrest within the first five days of hospitalization. In 38 of the 60 patients, some warning of the impending event occurred in the form of recurrent chest pain, cardiac arrhythmias or hypotension, whereas in 22 patients no premonitory symptoms or signs were noted. The cardiac arrests presented as ventricular fibrillation in 58%, ventricular standstill in 22% and some other arrhythmia in 20%. Although cardiac action was restored in 47 patients, 26 of whom had sinus rhythm, only 13 patients were restored to their pre-arrest status and only three were discharged from the hospital. All patients with acute myocardial infarction should be placed in a coronary-care unit, with continuous electronic monitoring for at least five days. When cardiac arrest is recognized, immediate attention should be given to the artificial circulation. External cardiac massage should be performed continuously and mouth-to-mouth or mouth-to-airway ventilation

Continued




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## ABSTRACTS

Continued

should be started. Concern with the electrical characteristics of the arrhythmia should be demonstrated only at this point. Ventricular standstill or other types of arrhythmia which do not yield an effective arterial pressure should be treated with intracardiac epinephrine.

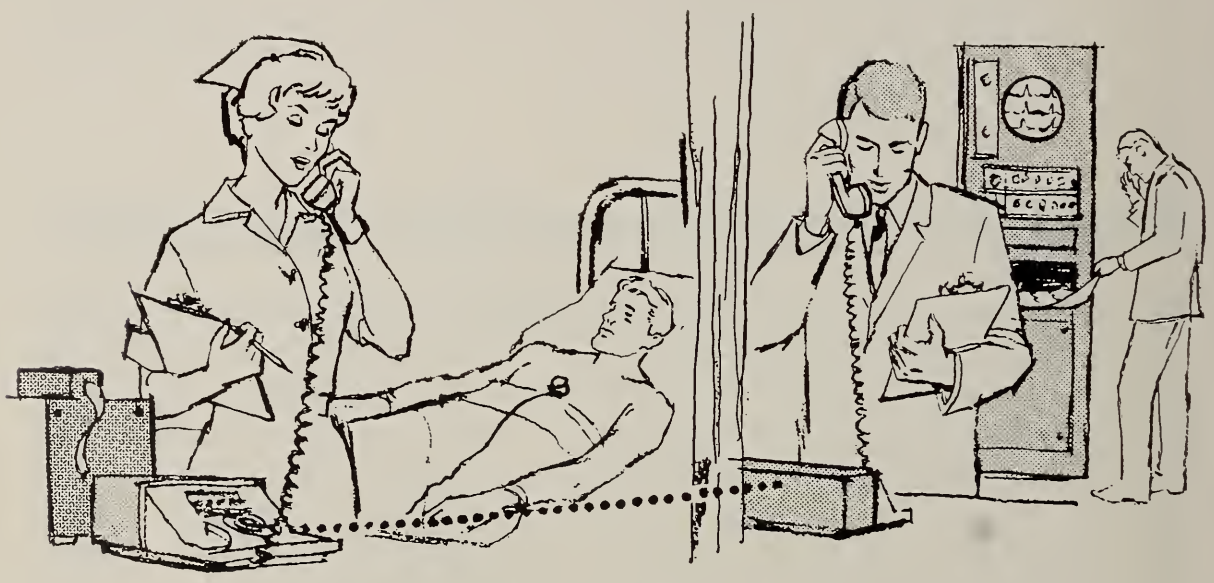
### CHROMOSOMAL ABERRATIONS IN SPONTANEOUS HUMAN ABORTIONS

A. E. Szulman (Magee-Womens Hosp., Pittsburgh)

*New. Eng. J. Med.* 272:811, (April 22), 1965.

Karyotypes of spontaneous abortuses, derived mainly from cells of amnion grown in short-term culture, revealed chromosomal aberrations in 16 of 25 cases (64%). A normal karyotype was found in nine cases. There were six trisomies (chromosomes 21, 16, 17-18, and 6-12), five cases of 45, XO and five cases of polyploidy (including one in a hydatidiform mole). A series of 15 cases from therapeutic abortions yielded normal karyograms.◄

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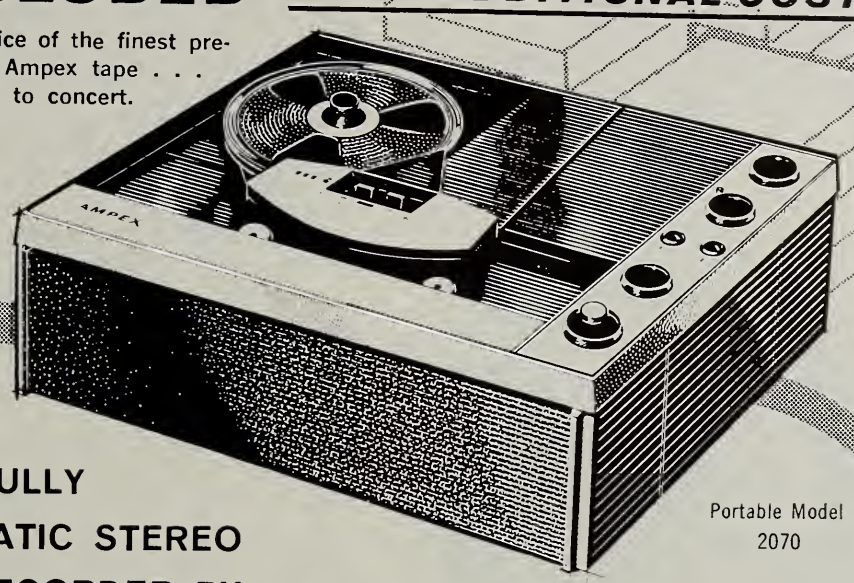
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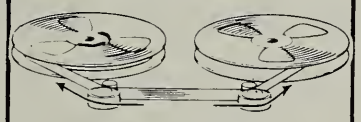
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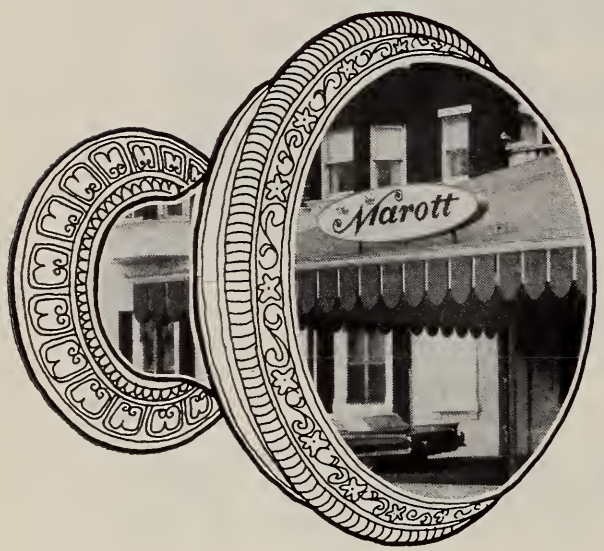
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Harold L. Saferstein, 36 Maplewick Lane, Willingboro, N. J.—*Dermatology*

Robert J. Kaufmann, 1424 W. Wood St., Decatur, Ill.—*Industrial Medicine*

Charles A. Earl, 508 N. Underwood, Kennewick, Wash.—*Industrial Medicine*

Whealen M. Koontz, Carol Ann Apt. B-38, Coralville, Iowa—*Internal Medicine*

Hans J. Nowicki, 2799 W. Grand Boulevard, Detroit, Mich.—*Internal Medicine*

Richard G. Neidballa, 6109 Upton Ave. South, Minneapolis, Minn. 55410—*Internal Medicine*

Stuart H. Wax, 2305 N. Berkshire Rd., Charlottesville, Va.,—*OB-GYN*

Albert J. Mintzer, 1418 Woodland, Des Moines, Iowa—*OB-GYN*

Kenneth D. Davis, 1510-A Werner Park, Fort Campbell, Ky.—*Orthopedics*

William VandenBerg, 9118 Irvington Ave., San Diego, Calif—*Ophthalmology*

Harold E. Stoner, 2901 South Parkway, Chicago, Ill.—*Psychiatry*

Howard S. Brown, 840 N. 24th St., Milwaukee, Wis.—*General Surgery*

Rustico C. Tongco, 422 Root Rd., Lorain, Ohio—*General Surgery*

### ADDITIONAL LOCATIONS

Benton—EARL PARK—Small community of 600 people located in the heart of a rich farming area. Building which was erected in 1946 especially for a doctor's office is available. The community has the schools, churches and financial income to support a physician who wants to live in the country. For further details contact Mr. William Gamso, Earl Park.

Madison—SUMMITVILLE—population 1,200. Opening for general practitioner. Located between Anderson and Marion where hospital facilities are available. Contact Mr. C. D. Bruning, Box 343, Summitville, for details.

Monroe—BLOOMINGTON—population between 35,000 and 40,000. Home of Indiana University. Newly decorated four-room office available. Need for additional general practitioners in Bloomington. Contact David C. Gray, 346 S. Walnut St., Bloomington, for details.

St. Joseph—SOUTH BEND—Population 140,000—located 90 miles east of Chicago. Home of Notre Dame University. Well established 13-year general practice available. Office building available. Two modern hospitals—open staff—located in South Bend. For further details contact Norman M. Holtzman, M.D., 3123 S. Michigan St., South Bend. ◄




## *TWO CARDIOLOGY TEACHING SCHOLARSHIPS ESTABLISHED BY HEART ASSOCIATION*

Two teaching scholarships in cardiology have been established by the American Heart Association as an added step in its long-range program to improve further the level of medical education in the field of cardiovascular disease. Previously established and in effect since 1962 has been a program to support research in medical education through the award of special fellowships.

The AHA is now seeking candidates for the new teaching scholarships who "show promise of excellent future development or have proven ability as medical teachers," to encourage them to devote the major part of their efforts to teaching.

The scholarships, which will support the recipients for a term of five years, were recently approved by the association's board of directors. The scholarship program will go into effect early in 1966.

Each scholarship will carry a base stipend of $11,000 for the first year, with annual increments of $1,000 up to a maximum of $15,000. An additional grant of $1,000 per year will be made to the teacher's institution, to cover expenses for travel, minor items of equipment or items for use in teaching.

Additional information and application forms may be obtained from Frederick J. Lewy, M.D., Director, Department of Medical Education, American Heart Association, 44 E. 23rd St. New York, N.Y. 10010.

## Mental Health Association to Honor Indiana Physician for Outstanding Work

The Mental Health Association in Indiana will honor an Indiana physician for outstanding service to the mentally ill by presenting $1,000 to the department of psychiatry of a medical school chosen by the award winner.

A citation will be presented to the recipient at the ISMA annual convention. The award will be given to the medical school in the name of the recipient.

## Dr. Gilbert H. White, Jr. Elected

Dr. Gilbert H. White, Jr. of Highland, Indiana, has been elected first vice-president of the University of Illinois Medical Alumni Association.

## *Dow's Pitman-Moore Division Awarded Cancer Research Contract*

The Pitman-Moore Division of The Dow Chemical Company, Indianapolis, will carry out the work on a contract awarded Dow by the Public Health Service, Department of Health, Education and Welfare to develop methods, equipment and facilities for protecting personnel and preventing cross-contamination of experiments in virus-cancer research.

Control of biohazards in virus research is one of four principal areas of investigation under a special virus-leukemia program for which the National Cancer Institute received a special congressional appropriation of $10 million for 1965. The other areas to be investigated are: the cause and prevention of human leukemia, treatment of human leukemia and animal leukemias and their possible relationships to man. The contract involves approximately $1 million.

## Three Indiana Physicians Speak at National Flying Physicians Meeting

Edward D. Miller, M.D., Fort Wayne; Charles H. Loomis, M.D., Richmond and C. Basil Fausset, M.D., Indianapolis, were featured speakers at the 11th annual meeting of the Flying Physicians Association last month in Miami Beach.

The association was founded to promote safety in general aviation and to explore the various medical disciplines as they relate to aviation. The 1,700 members live in all 50 states and in foreign countries.

## *I. U. School of Medicine Receives Grant to Establish Scholarship*

A sum of $45,294 has been given to the Indiana University School of Medicine as a scholarship fund by a Rush County, Indiana native although she was not a graduate nor had any other direct connection with the university.

The money, in the form of a bequest from the will of the late Mrs. Florence Abercrombie of Rushville, was presented to the I. U. Board of Trustees to be used for the Theodore Abercrombie Scholarship, a memorial to her late husband.

The Abercrombie will stipulates that the recipients of the scholarships must be graduates of an Indiana high school, with preference to go to residents of Rush County. The Abercrombies, lifelong residents of Rush County, had no children.

Continued

## New Robins Representative

Robert C. Troke has joined A. H. Robins Company as a medical service representative.

Troke, who attended Butler University, has been assigned to the company's central division and will be working in the Indianapolis area.

## *Wyeth Fund Again Sponsoring Pediatric Residency Fellowships*

The Wyeth Fund is sponsoring its Pediatric Residency Fellowships again for the residency year 1966-67. Application forms may be obtained by writing Dr. Philip S. Barba, 120 Erdenheim Road, Philadelphia, Pa. 19118. All applications must be filed by December 1.

Each fellowship provides, in addition to the normal stipends, a total of $4,800 over a two-year period for the purpose of advanced study. Residencies must be served in an institution which is accredited by the AMA Residency Review Committee, the American Board of Pediatrics or the American Academy of Pediatrics.

## Three Hoosier Physicians Named To AMA'S Scientific Assembly

Three Hoosier physicians were among the top officers of the AMA's Scientific Assembly elected at the AMA June Convention.

Dr. Maurice I. Marks of Indianapolis was elected chairman of the Section on Military Medicine and Dr. Myron Nourse, also of Indianapolis, was named chairman of the Section on Urology.

Dr. Lall G. Montgomery of Ball Memorial Hospital, Muncie, was nominated a delegate of the Section on Pathology and Physiology.

Much of the planning and scheduling of the scientific program of the AMA Annual Conventions is done by the officers of the association's 22 scientific sections.

## *Michigan State Medical Society Celebrating 100th Anniversary*

The Michigan State Medical Society is celebrating its 100th anniversary at its Centennial Session in Detroit from September 19 to 24.

Each of the six days of the meeting has been assigned a special theme with all scientific, professional and social events arranged around and in support of the correlation of medicine with religion, business, medical organizations, science, voluntary health and government.

## New Ames Medical Director

Joseph B. Kopp, M.D., has been appointed Associate Medical Director of Ames Company of Elkhart. Dr. Kopp was formerly associated with Wyeth Laboratories.

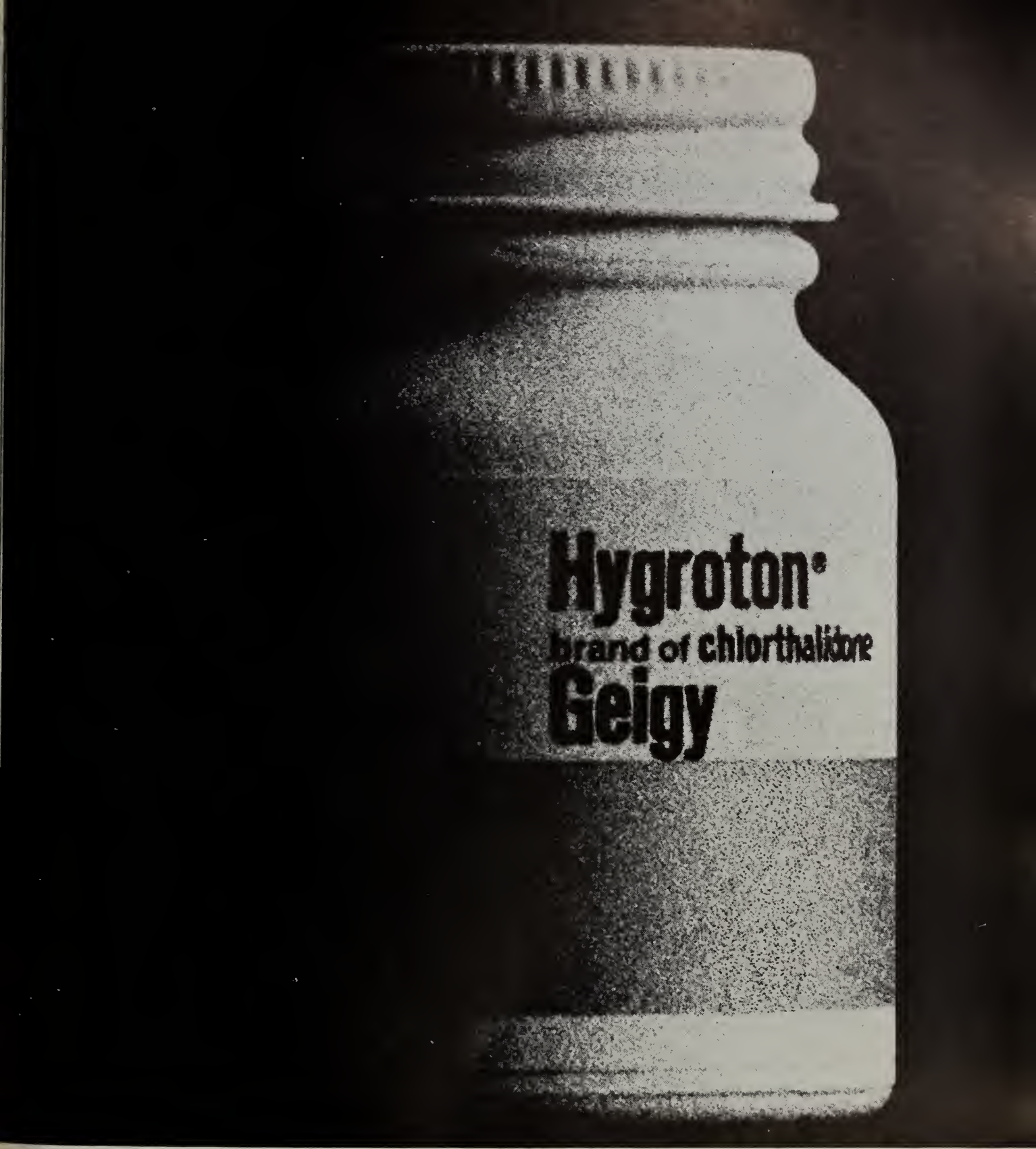
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Precautions: Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
Side Effects: Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
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## NEWS NOTES

Continued

### *National Pharmacy Week Will be October 3 to 9*

National Pharmacy Week will be observed for the 41st time October 3 to 9. The American Pharmaceutical Association is making plans to emphasize the role of the pharmacist in better community health.

Coincidentally the APA and the retail pharmacists are also making plans to participate in the AMA's observance of Community Health Week, November 7 to 13.

### *ISMA Woman's Auxiliary Given Awards at AMA Annual Convention*

The Woman's Auxiliary of the Indiana State Medical Association and one of its component societies, the Woman's Auxiliary to the Vanderburgh-Southwestern Indiana Medical Society received awards at the New York City AMA meeting for their respective excellence in financial aid to the AMA Education and Research Foundation.

The Indiana auxiliary made the greatest contribution of any state group in the 2,001 to 3,000 member category, $14,656.97. The Vanderburgh-Southwestern Indiana group, with a membership of 187, contributed $2,480.40. Total national contribution by the Woman's Auxiliary to the AMA amounted to $320,121.87. These moneys are given in part to medical schools for unrestricted use, and also to the student loan guaranteed fund which produces $1,250 in loans for each $100 contributed.

### New Robins Representative

Robert E. Baareman recently joined A. H. Robins Company as a medical representative. He will be working in the South Bend area.

### *Pfizer & Co., Inc. Names New President*

John J. Powers, Jr., has been elected president and chief executive officer of Chas. Pfizer & Co., Inc.

Mr. Powers succeeds John E. McKeen who served as president of the pharmaceutical company from 1949. Mr. McKeen will continue to serve as chairman of the board and chairman of the executive committee.

### Dr. Bittle Appointed

James L. Bittle, D.V.M., has been made head of the Virus Research Department of Pitman-Moore. He succeeds Dr. A. J. Schwarz who recently was appointed Director of Research for Dow Human Health Products.

### Dr. Peirce Promoted

Dr. James D. Peirce, Indianapolis, has been promoted to director of the industrial medicine division of Eli Lilly and Company. He has been assistant director of personnel relations since 1955. ◄


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# FUTURE MEETINGS, SEMINARS, COURSES

## *"Hyperbaric Oxygenation" is Topic For ISMA Section on Surgery Meeting*

The luncheon meeting of the Section on Surgery during the ISMA annual convention will feature a symposium on "Hyperbaric Oxygenation." The meeting will be at Monte's in Riley Center, a short walk from the Murat Temple.

The time is 12 noon, with adjournment in time to attend the 2 p.m. meeting at which Dr. Appel, President of the AMA, will speak. Tickets for the luncheon may be obtained in advance at the registration desk. All interested members and guests, whether members of the section or not, are invited.

## Postgraduate Course in "Common Problems in General Practice" Set

A postgraduate course in "Common Problems in General Practice — Office Procedures" will be conducted October 29 and 30 at the Mound Park Hospital Foundation in St. Petersburg, Florida.

The program is acceptable for 14 accredited hours by the American Academy of General Practice. There is no registration fee. Write the Foundation at 701 Sixth St. South, St. Petersburg 33701 for complete information and reservations. Attendance may be limited.

## *Medical Seminar on Obstetrics and Gynecology to be Given on Cruise*

A medical seminar cruise on obstetrics and gynecology will be conducted by the University of Florida aboard the S. S. Ariadne from February 28 to March 4, 1966. The faculty will consist of Dr. Nicholson Eastman and Dr. S. L. Israel.

Two days of the cruise to Nassau and Freeport will be set aside for lectures each morning and round table discussions in the afternoons. Details on cruise reservations may be obtained by writing E. M. Baskette, Eastern Steamship Line, P. O. Box 882, Miami, Florida 32101.


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## American Association of Medical Assistants to Meet in New York City

An educational seminar for medical assistants is planned by the American Association of Medical Assistants for their annual meeting in New York City on October 13 to 17.

There will be a symposium on office management as well as talks on interpersonal relations with patients and a trip to the World's Fair to see, among other sights, the Atomedic Hospital.

## *Pan-Pacific Surgical Association Will Conduct its Tenth Congress*

The Pan-Pacific Surgical Association will conduct its tenth congress on September 20 to 28, 1966 in Honolulu. Two traveling educational seminars are planned after the regular congress.

One trans-Pacific tour will visit Japan and Hong Kong from September 28 to October 10, and terminate on October 10 in San Francisco. A longer tour will extend from September 28 to November 1 and in addition to Japan and Hong Kong, will visit the Philippines, Thailand, India, Singapore, Australia and New Zealand. For further information write Pan-Pacific Surgical Association, Room 236, Alexander Young Bldg., Honolulu 96813.

## Postgraduate Course in Anesthesiology Offered ISMA Members

A postgraduate course in anesthesiology will be held on October 13 at the University of Louisville. The entire day's program will be devoted to local and regional anesthetics.

All members of the ISMA are invited to attend. Additional information may be obtained by writing to Dr. Donald M. Thomas, University of Louisville School of Medicine, 323 E. Chestnut St., Louisville 40202.

## AMA Sponsors National Conference On the Medical Aspects of Sports

The seventh National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held in Philadelphia, Pennsylvania, at the Benjamin Franklin Hotel on November 28. The conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association. In addition, the conference will be held in cooperation with the observance of the bicentennial anniversary of the University of Pennsylvania's School of Medicine and of medical education in the United States.

The conferences will cover a wide range of

## to help relieve pain in common anorectal disorders

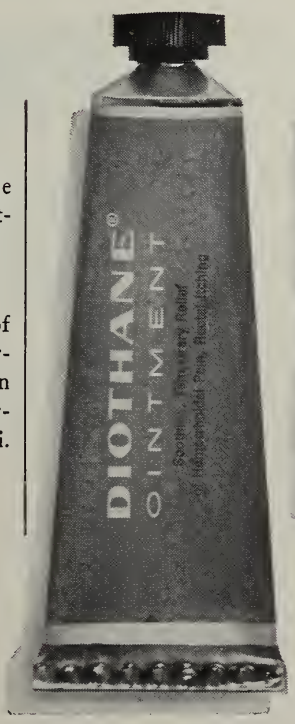
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subjects of interest to physicians, especially those serving school and college sports programs. Included will be papers, panels and discussions relating to readiness for sports participation, management of health problems in sports and application of research to injury prevention.

Those interested in receiving further information concerning the conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

### *ISMA Members Invited to American Automotive Medicine Meeting*

The American Association of Automotive Medicine will meet on October 22 and 23 at the Mayo Clinic. The program will be medically oriented and will be of general interest in the field of automotive safety and accident prevention.

Members of ISMA are invited. The registration fee is $20. To register write: Postgraduate Courses, Mayo Clinic, Rochester, Minnesota 55902.

### American Fracture Association Lists Dates of Future Meetings

The American Fracture Association cordially invites all physicians who are interested in various types of fracture treatment to attend the annual meeting to be held at the Riviera Hotel in Las Vegas, Nevada, October 24 to 28.

The American Fracture Association, whose membership includes physicians from North, Latin and South America, is the only organization which limits its entire programs to the treatment of fractures by various methods.

In 1966 the annual meeting will be held in Caracas, Venezuela, November 1 to 5, and in 1967 will be held at the Sheraton-Chicago Hotel in Chicago, Illinois, October 28 to November 2.

Any physician interested should contact Dr. H. W. Wellmerling, Secretary General, 610 Griesheim Building, Bloomington, Ill.

### *Inaugural Scientific Program of New Ancker Hospital in November*

The inaugural scientific program of the new Ancker Hospital will be held at the hospital in St. Paul, Minn., on November 11, 12 and 13. All members of the ISMA are invited to attend.

There will be two days of general medical meetings and one-half day specialty meetings. The principal address will be given by Dr. Martin Cummings, Director of the National Library of Medicine. For further information write to Dr. James F. Hammarsten, Ancker Hospital, St. Paul, Minn.

### Hodgkin's Disease to be Subject Of November Symposium in New York

Hodgkin's disease will be the subject of a symposium to be presented on November 22 at the New

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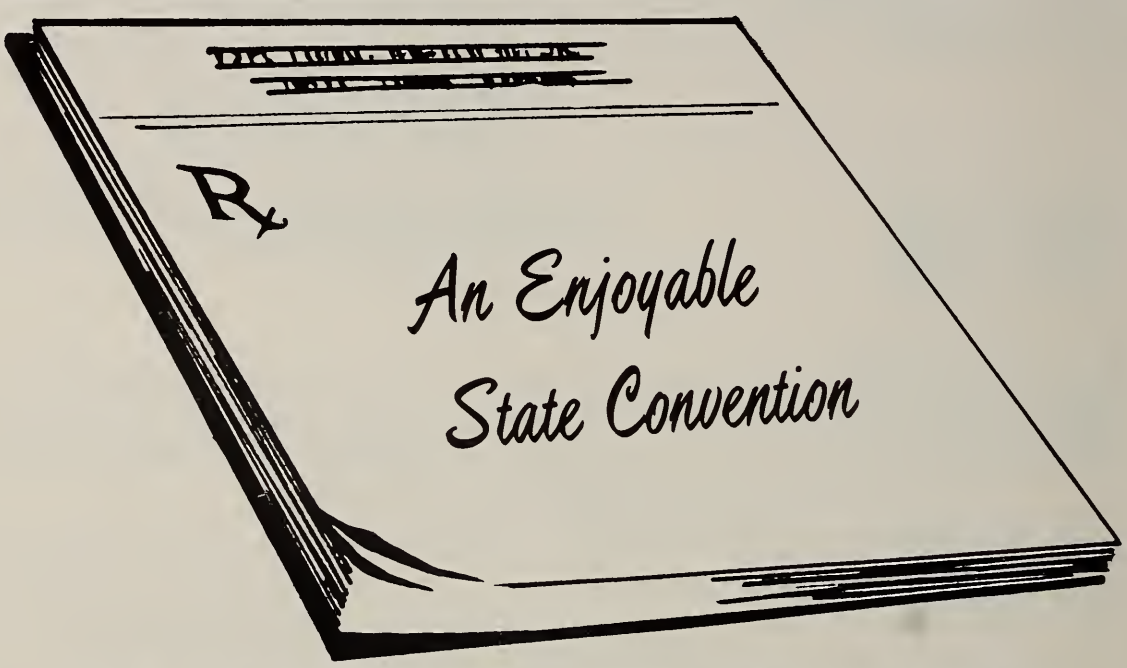
The co-sponsors are the American Cancer Society and the National Cancer Institute. Full information may be obtained by writing Dr. Jack W. Milder, 219 E. 42nd St., New York City 10017.

### *Psychiatry Courses Offered By The Chicago Medical School*

To meet the growing need for further training and experience in the areas of psychiatric diagnosis and treatment for general practitioners and physicians other than psychiatric specialists, basic and advanced courses will again be offered by the Department of Psychiatry and Neurology of The Chicago Medical School.

The aim of the postgraduate program is to increase the skills of the physician in the diagnosis and treatment of his general patient case load and in the management of the psychiatric problems which require limited goal therapy.

Courses will begin on October 13, 1965. There is a limited enrollment and advance registration is required. Address communications to: Bernard Block, M.D., Director — Continuing Education, Department of Psychiatry and Neurology, The Chicago Medical School, 2755 W. 15th St., Chicago, Ill. 60608. ◄


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# Annual Meeting Dates of Professional Medical and Allied Organizations

**AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION**
Date Nov. 28—Dec. 1, 1965
Place Philadelphia, Pa.

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date May 3-5, 1966
Place Fort Wayne

**BONE AND JOINT CLUB**
Date October 13
Place The Athenaeum, Indianapolis

**INDIANA HOSPITAL ASSOCIATION**
Date October 27-29, 1965
Place French Lick

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

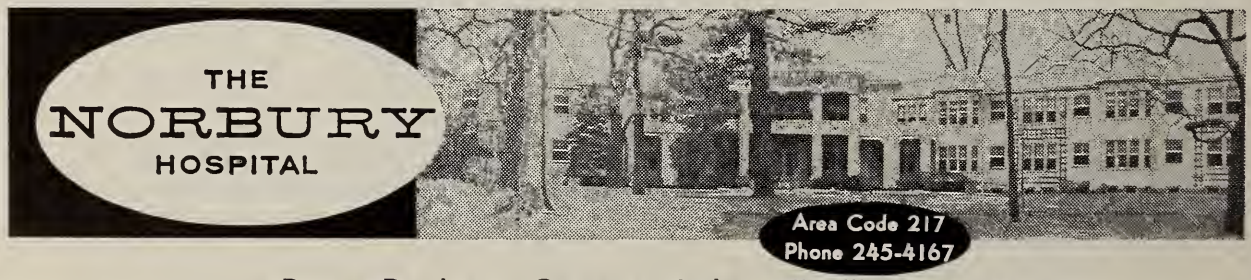
**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 12-14, 1965
Place Murat Temple, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
Date Sept. 25-26, 1965
Place South Bend

**INDIANA ROENTGEN SOCIETY**
Date October 12, 1965
Place The Athenaeum, Indianapolis

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


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# County, District News

## Bartholomew-Brown

Dr. George C. Weinland has been installed as president of the Bartholomew-Brown County Medical Society. Assisting him will be Drs. Robert B. Krueger, Columbus, vice-president; J. E. Overmire, secretary-treasurer; Harold W. Richmond and Robert Seibel, delegates and Lloyd Gammell, alternate. All of the new officers are from Columbus except Dr. Seibel; he is from Nashville.

## Clinton

The Clinton County Medical Society met July 27 to hear Dr. Francis Carrel, Frankfort, speak on "The Arterial Perfusion Method of Treating Cancer." Fourteen members attended.

## Dearborn-Ohio

Newly installed president of the Dearborn-Ohio County Medical Society is Dr. Edwin L. Gresham, Aurora. Other new officers are: Drs. Brockton L. Weisenberger, Lawrenceburg, vice-president; J. K. Jackson, Aurora, re-elected secretary-treasurer; Leslie M. Baker, Aurora, and Gordon S. Fessler, Rising Sun, delegates and Ivan Lindgren, Lawrenceburg and Amado Mauricio, Rising Sun, alternates.

## Floyd

Dr. Bogdan Nedelkoff is the 1965-66 president of the Floyd County Medical Society. Other officers are: Drs. J. H. Geyer, vice-president; D. H. Cannon, re-elected secretary-treasurer; Donald R. LaFollette, delegate and Irvin H. Sonne, Jr., alternate. All of the new officers are from New Albany.

## Montgomery

New president of the Montgomery County Medical Society is Dr. Claude N. Thompson, Waynetown. Other officers include: Drs. Malcolm K. Baird, Crawfordsville, vice-president; Wesley E. Shannon, Crawfordsville, re-elected secretary-treasurer; Richard R. Eggers, Crawfordsville, delegate and J. M. Kirtley, Crawfordsville, alternate.

## Orange

Field Representative Robert Amick met with members of the Orange County Medical Society August 3 to discuss legislative measures and the outlook for the future in view of these bills. Nine members attended.

## Washington

The Washington County Medical Society met July 27 for an open discussion by the staff regarding hospital problems. Four members attended. ◄

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**Precautions**
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

**Warning:** If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

**Side effects**
The most common side effects are nausea, edema and drug rash. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

**Contraindications**
These include: edema, hypertension, or danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient cannot be seen regularly, when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin® alka are contraindicated in patients with glaucoma.

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# Deaths

## Philip H. Becker, M.D.

Dr. Philip H. Becker, superintendent of Parramore Hospital at Crown Point for 26 years, died July 27 at the age of 58.

Dr. Becker had retired from his position at the Lake county tuberculosis sanitarium just two months prior to his death. A graduate of Marquette University in 1932, Dr. Becker went to Lake county in 1933 to work at Parramore. He succeeded Dr. Parramore as head of the sanitarium after the latter's death in 1939. He was a member of the Lake County Medical Society.

## Erwin Blackburn, M.D.

Dr. Erwin Blackburn, 66, chief physician in charge of the female geriatrics service at Beatty Memorial Hospital, Westville, died July 29 in Memorial Hospital, South Bend.

Dr. Blackburn had been a physician in South Bend for 40 years before going to Beatty Hospital about four years ago. A member of the St. Joseph County Medical Society, Dr. Blackburn was graduated from the I. U. School of Medicine in 1923. He was a veteran of World Wars I and II, serving first with the U.S. Army and later as a commander in the U.S. Navy.

## DeVon W. Frash, M.D.

Dr. DeVon W. Frash, 65-year-old general practitioner, died July 29 at South Bend.

A physician and surgeon in South Bend since 1930, Dr. Frash was graduated from the Northwestern University Medical School in 1928. He was a veteran of World War I and was on the visiting staff of Memorial and St. Joseph Hospitals at South Bend. He was a member of the St. Joseph County Medical Society.

## Homer E. Glock, M.D.

Dr. Homer E. Glock, former Ft. Wayne resident and father of two Indiana physicians, died May 19 at the age of 87.

Dr. Glock died at Fort Pierce, Fla., where he had been residing the last eight years following his retirement. A member of the ISMA 50-Year Club and the Allen County Medical Society, Dr. Glock was graduated from the Ft. Wayne Medical College in 1903. He began his practice in Larwill in 1903, moved to Harlan and after completion of his graduate studies, moved to Fort Wayne where he practiced medicine 50 years. He was the father of Dr. Wayne R. Glock and Dr. Maurice E. Glock, both of Fort Wayne.

## Donald D. Johnston, M.D.

Dr. Donald D. Johnston, former Indiana physician, died June 27 at the home of his son in Thousand Oaks, Calif. He was 81.

Dr. Johnston was graduated from the University of Michigan School of Medicine in 1908. He

Continued


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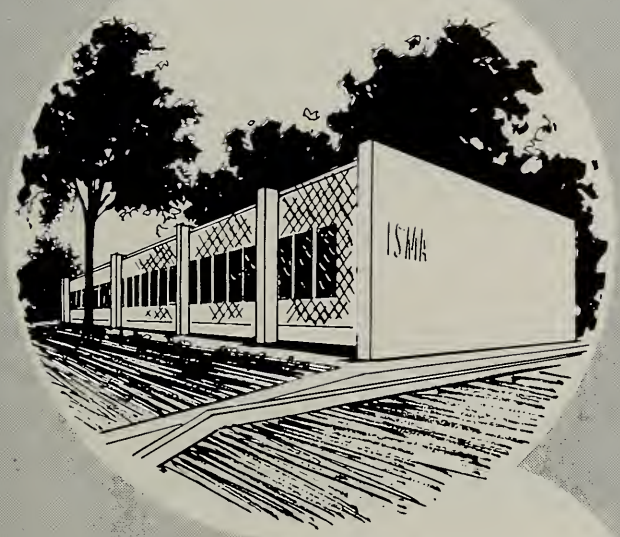
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**October 12-14, 1965**

***General physicians provide health care to the vast majority of the working population. This meeting will provide invaluable background information to help these physicians in their daily practice.***

**Subjects to be covered include:**

**Role of the Family Physician in regard to:**
Disability and Workmen's Compensation, Immunization, Emphysema, Recognition of Disturbed Employees, and Cardiac Problems.

**Also included are:**
Varied medical programs sponsored by the medical association sections, as well as the annual "Fireside Medical Conferences."

A Clinical-Pathological Conference, and a Medical-Socio-Economic Conference.

*And don't miss the "Gay 90s Gaslight Party" on Wednesday evening, October 13.*

**Acceptable for accredited hours by the AAGP.**

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(city) (state) (zip code)

*(Mail to AMA Department of Occupational Health, 535 North Dearborn Street, Chicago, Illinois 60610.)*

## DEATHS

Continued

opened his practice in Kendallville in 1912, moved to Fort Wayne in 1920 and practiced there until 1941 when he went into the U.S. Army for six years. From 1947 to 1955, he was affiliated with the Veterans Administration and then went to Beatty Memorial Hospital at Westville where he served until 1964. He was a member of the ISMA 50-Year Club and the Fort Wayne Medical Society.

### Franklin P. McDaniel, M.D.

Dr. Franklin P. McDaniel, 84, of Atlanta, Ind., died July 17 at Noblesville after a two year illness.

Dr. McDaniel was graduated from the old Medical College of Indiana in 1906 and practiced medicine in Atlanta for 59 years. He was a past president of the Hamilton County Medical Society and joined the ISMA 50-Year Club in 1956.

### C. W. Rutherford, M.D.

Dr. Cyrus W. Rutherford, noted Indiana eye specialist, died August 2 in Urbana, Ill. He was 90 years old.

Dr. Rutherford was graduated from the old Medical College of Indiana in 1899 and went to Newman, Ill., his birthplace, as a general practitioner. He remained there until 1921, when he moved to Indianapolis and began to specialize in the treatment of eye ailments. Dr. Rutherford moved to Iowa City in 1928 to become associate professor of ophthalmology at the State University of Iowa Hospital and College of Medicine.

He returned to Indianapolis in 1935, practicing here until his retirement in 1945. Dr. Rutherford also served as an associate professor of ophthalmology at Indiana University; was a staff member of Marion County General Hospital, member of the ISMA 50-Year Club and the Marion County Medical Society.

### Frank A. Van Sandt, M.D.

Dr. Frank A. Van Sandt, 88, practicing physician in Green County for nearly 60 years, died June 10 in Indianapolis.

The retired 88-year-old physician, graduated from Barnes Medical College in 1899, practiced in Bloomfield from 1902 until his retirement in 1962. He was a member of the ISMA 50-Year Club and the Greene County Medical Society. ◄

## ROSTER AND YEARBOOK ISSUES

The Roster and Yearbook issue of the Indiana State Medical Association is now available. Included in the Roster are the names of all members of the ISMA listed alphabetically and by counties, plus the names of all the Woman's Auxiliary.

The Yearbook, besides carrying the Roster, includes listings of the following: State Health Organizations; Professional Medical and Allied Organizations; Voluntary Organizations; Heads of Departments at the I. U. School of Medicine; Indiana Accredited Practical Nursing Schools; Approved Hospitals in Indiana; Approved Mental Hospitals; Licensed Nursing Homes; Poison Control Centers in Indiana: Disease Prevention by Immunization and Chemoprophylaxis and Class A Narcotic Drugs.

If you would like to order either or both of these special issues, please check the appropriate box and send it along with your check or money order to *The Journal*, 3935 N. Meridian St., Indianapolis 8.

☐ Roster — $3.00

☐ Yearbook — $5.00

Name_____

Address_____

City_____

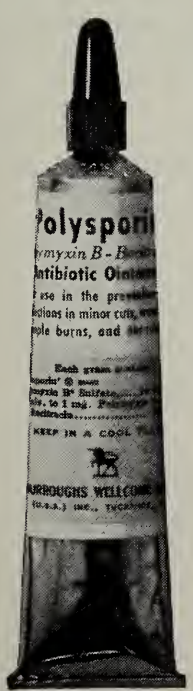
State_____

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—July, 1965

| Disease | July 1965 | June 1965 | May 1965 | July 1964 | July 1963 |
|---|---|---|---|---|---|
| Animal Bites | 1077 | 1575 | 1179 | 1304 | 833 |
| Chickenpox | 110 | 304 | 312 | 125 | 58 |
| Conjunctivitis | 96 | 156 | 126 | 181 | 44 |
| Diphtheria | 0 | 0 | 0 | 1 | 2 |
| Dysentery, Unspecified | 40 | 53 | 158 | 58 | 6 |
| Gonorrhea | 317 | 443 | 438 | 367 | 289 |
| Impetigo | 156 | 143 | 118 | 252 | 78 |
| Infectious Hepatitis | 47 | 52 | 56 | 46 | 25 |
| Infectious Mononucleosis | 38 | 40 | 64 | 45 | 8 |
| Influenza | 205 | 199 | 278 | 217 | 90 |
| Measles (Rubeola-Rubella) | 144 | 629 | 705 | 548 | 241 |
| Meningitis, Meningococcal | 3 | 7 | 5 | 3 | 2 |
| Meningitis, Other | 3 | 6 | 8 | 4 | 7 |
| Mumps | 116 | 324 | 285 | 270 | 101 |
| Pertussis | 10 | 13 | 6 | 79 | 102 |
| Pneumonia | 124 | 182 | 133 | 135 | 60 |
| Poliomyelitis | 0 | 0 | 0 | 1 | 0 |
| Streptococcal Infection | 421 | 437 | 463 | 513 | 132 |
| Syphilis | | | | | |
| Primary & Secondary | 1 | 92 | 5 | 7 | 6 |
| All Other Syphilis | 81 | 7 | 103 | 126 | 114 |
| Tinea Capitis | 16 | 14 | 5 | 6 | 2 |
| Tuberculosis (Active) | 75 | 125 | 83 | 135 | 110 |


**in treating topical infections, no need to sensitize the patient**




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# POLYMYXIN B-BACITRACIN
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# SUPPORT THESE PROGRAMS OF THE AMA-ERF

- *Funds for Medical Schools* -- Contributions may be designated for one particular school. Undesignated contributions will be distributed equally among all medical schools. No restrictions are placed on the use made of this money by the schools.
- *Loan Guarantee Fund* -- Provides guaranteed loans to medical students, interns and residents. For every dollar in the fund, the private banking industry loans $12.50, at a maximum rate of 6% simple interest.
- *Honors and Scholarship Program* -- Designed to attract students of high promise to careers in medicine—meetings, personal contacts and written materials will be employed. Medical school scholarships will be available to those who need them.
- *Undesignated Contributions* -- Money not designated for any specific AMA-ERF program will be placed in the general fund and the Board of Directors will decide on its use, depending upon need.

AMA-ERF

**American Medical Association**
**Education and Research Foundation**
**535 North Dearborn Street**
**Chicago 10, Illinois**

# Association News

## EXECUTIVE COMMITTEE

June 20, 1965

Meeting called to order at 8:00 p.m. in the Americana Hotel, New York City, with Dr. Eugene S. Rifner presiding in the absence of the chairman, Dr. Ralph V. Everly.

Present: G. O. Larson, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D., Lester Hoyt, M.D., and James A. Waggener, executive secretary.

Guest: Frank K. Woolley, AMA field representative.

### Membership Report

| | |
|---|---|
| Number of members as of December 31, 1964 | 4,365 |
| 1965 members as of May 31, 1965 | 4,316 * |
| Number of members as of May 31, 1964 | 4,294 |
| Gain over last year | 22 |
| Number of AMA members as of May 31, 1965 | 4,214 |
| Total 1964 AMA members as of May 31, 1964 | 4,180 |
| Gain over last year | 34 |
| 1965 AMA members: Dues paying | 3,699 |
| Exempt, but active | 515 |
| | 4,214 |
| Number who have paid state dues but not AMA dues as of May 31, 1965 | 102 |

* Includes 302 senior and 3 honorary members

### Headquarters Office

The secretary read a report concerning the action of the Internal Revenue Service in taxing the Michigan Dental Association on unrelated income.

The secretary raised the question concerning the policy of the use of the association's attorneys for legal opinions for hospital staffs, county medical societies and individual members. After discussion, it was decided to refer this question to the Council upon the motion of Drs. Neumann and Black.

A resolution for presentation to the AMA House of Delegates was approved for presentation, upon motion of Drs. Neumann and Larson.

### Treasurer's Office

The treasurer reported on the financial condition of the association as of May 31 and on the cash balances as of June 15. This report was approved on motion of Drs. Larson and Neumann.

### Annual Convention, October 12-14, 1965, Indianapolis

Fifty-Year Club response. By consent, Dr. Charles W. Myers of Indianapolis was selected to give the response for the Fifty-Year Club.

By consent it was agreed to ask Dr. Will C. Moore of Muncie to serve as chairman of the Fifty-Year Club reception.

### Legislation

*National*—Mr. Woolley reviewed the status of Medicare before the Congress, and letters of reply received by the president and hospital trustees were reviewed for the information of the committee.

### Organization Matters

A letter addressed to the president from O. Thomas Montgomery, D.C., was reviewed, as was a letter from the association's legal counsel, and on motion of Drs. Larson and Neumann, it was agreed that the recommendation of the legal counsel should be followed.

A letter to Dr. Joseph Weber, as directed at a previous meeting of the Executive Committee, was reviewed and it was reported that no reply was received. This was accepted as a matter of information.

The matter deferred from the previous Executive Committee meeting concerning advertising for interns in the Student AMA *Journal* was discussed and upon motion of Drs. Black and Larson, an attempt is to be made to find out if the hospitals of the state would have room for interns if they could be obtained in this way and if there is any chance of the hospital group assisting in the payment of the cost of the advertising.

Excerpts of the minutes of the Blue Cross Labor Advisory Committee meeting were reviewed for the information of the committee.

A request of the Indiana Hospital Association for a meeting to discuss emergency room procedures was read and on motion of Drs. Larson and Olvey, the president was empowered to appoint representatives to meet with the hospital group for this discussion.

A letter from Dr. Robert C. Bolin, Lafayette, was reviewed and by consent this was referred to the Liaison Committee with I. U. School of Medicine.

Resolutions adopted by the Indiana Academy of Ophthalmology and Otolaryngology were reviewed and on motion of Dr. Larson, taken by consent, these resolutions were accepted for information. Upon motion of Drs. Larson and Neumann, the secretary was to write to the academy pointing out the position of the association, that physicians should be paid the usual and customary fees under the blind assistance program. Also, Dr. Edwin W. Dyar, the state director of this program, is to be so advised.

Letter concerning the appointment of a member of the Indiana State Medical Association to the Advisory Committee for Medical Assistance for the Aged was read and it was taken by consent that the president would fill this appointment.

Comments from three Indiana physicians in reply to notification by the American Medical Association that their dues had not been received were read, and on motion of Dr. Larson, taken by consent, a letter is to be written to these doctors urging them to reconsider their position.

A letter from the AMA concerning the chiropractic situation developing in the northern part of the state was reviewed and upon motion of Drs. Black and Larson, the society members are to be contacted to determine more about this matter and to learn what help, if any, they need.

Participation in Indiana Health Careers, Inc., in the amount of $100.00 was approved on motion of Drs. Larson and Hoyt.

A resolution adopted by the Indiana State Dental Association concerning consolidation of some of the health agencies was read and upon motion of Dr. Neumann, taken by consent, the secretary is to outline what the operation of this type of an agency should be, what services should be included and the estimated cost.

Resolution of the Indiana State Dental Association concerning a dental program under Blue Shield was read for the information of the committee.

The activities of the Los Angeles County Medical Society in the field of Medicare legislation was reported for the information of the committee.

By consent it was agreed that *The Journal of the Indiana State Medical Association* should purchase a share of stock in the amount of $200.00 in the State Medical Journal Advertising Bureau, Inc.

## EXECUTIVE COMMITTEE

June 20, 1965

Upon the call of Dr. Eugene S. Rifner, chairman of the Council, the Executive Committee met with AMA delegates and alternate delegates at the Americana Hotel in New York City, at 8:00 p.m., Sunday, June 20, 1965.

Present: Eugene S. Rifner, M.D.; Kenneth O. Neumann, M.D.; Guy A. Owsley, M.D.; Robert M. Brown, M.D.; G. O. Larson, M.D.; Joe M. Black, M.D.; Ottis N. Olvey, M.D.; William B. Challman, M.D.; Harold C. Ochsner, M.D.; E. S. Jones, M.D.; Francis L. Land, M.D.; Lester Hoyt, M.D.; Frank H. Green, M.D.; Jack E. Shields, M.D.; John M. Paris, M.D.; Lester D. Bibler, M.D.

James A. Waggener, executive secretary and Kenneth W. Bush, administrative assistant.

Guests: Frank K. Woolley, AMA field representative; Wendell C. Stover, M.D.; Glenn W. Irwin, Jr., M.D.; Don E. Wood, M.D., and Arthur G. Loftin, executive secretary, Marion County Medical Society.

Dr. Rifner outlined the assignments for the members of the Executive Committee and the delegates for being present in the Indiana hospitality room.

The resolution to be introduced before the AMA was discussed and it was agreed that Dr. Jones would formally introduce the resolution before the House of Delegates.

Mr. Woolley gave a detailed report on the situation before the Congress and the Senate Finance Committee with respect to H. R. 6675. By consent it was agreed that the Indiana delegation should work for the support of the Indiana resolution and would oppose those resolutions calling for strict non-participation.

The group invited Dr. Durward G. Hall to appear before them at 10:00 p.m. in behalf of his candidacy as president-elect of the American Medical Association.

It was decided if other candidates cared to appear before the delegation, they would be invited to do so at the breakfast meeting of the delegates.

There being no further business, the group adjourned to meet again at 7:30 a.m. Monday, June 21, 1965.

## EXECUTIVE COMMITTEE

July 17, 1965

Meeting called to order at 3:00 p.m. and in the absence of the chairman, Dr. G. O. Larson assumed the chair.

Present: G. O. Larson, M.D., K. O. Neumann, M.D., Eugene S. Rifner, M.D., Ottis N. Olvey, M.D., Lester Hoyt, M.D., and James A. Waggener, executive secretary.

Frank Ramsey, M.D., editor of *The Journal.*

### Membership Report:

| | |
|---|---|
| Number of members as of December 31, 1964 | 4,365 |
| 1965 members as of June 30, 1965 | 4,340 * |

* Includes 302 senior and 3 honorary members

| | | |
|---|---|---|
| Number of members as of June 30, 1964 | | 4,324 |
| Gain over last year | | 16 |
| Number of AMA members as of June 30, 1965 | | 4,239 |
| Total 1964 AMA members as of June 30, 1964 | | 4,215 |
| Gain over last year | | 24 |
| 1965 AMA members: | Dues paying | 3,714 |
| | Exempt, but active | 525 |
| | | 4,239 |
| Number who have paid state dues but not AMA dues as of June 30, 1965 | | 101 |

### Headquarters Office

The request of the Indiana Public Health Association for the association to print their news letter on the basis of two or three times a year was reviewed and inasmuch as this involved only

A letter from *The Illinois Medical Journal* inquiring if the Indiana State Medical Association would be interested in consolidating the Indiana *Journal* with that of Illinois was reviewed and by consent, the secretary is to inform the Illinois State Medical Society that Indiana is not interested.

### Future Meetings

An invitation to send three representatives at AMA expense to the National Congress on Medical Ethics, to be held on October 2 and 3, 1965, at the Drake Hotel, Chicago, was reviewed. Upon motion of Dr. Hoyt, taken by consent, the president was empowered to appoint three representatives to attend this meeting.

The AMA National Symposium on Venereal Disease Control, to be held in Chicago on November 20, 1965, was noted as a matter of information. No action was taken.

There being no further business the committee adjourned to meet again at the headquarters office at 3:00 p.m., Saturday, July 17, 1965.

the use of our printing equipment, the request was granted on motion by Dr. Neumann and seconded by Dr. Olvey.

## Building Matters

The secretary discussed the illumination of the parking lot and presented a contract by the Indianapolis Power and Light Company. The contract was approved upon motion of Dr. Neumann and taken by consent.

The secretary reviewed correspondence concerning the 40th Street exit for the information of the committee and no action was taken.

## Treasurer's Office

The treasurer's report was approved on motion of Drs. Rifner and Neumann. On motion of Dr. Rifner and seconded by Dr. Neumann, the treasurer was instructed to apply an additional $3,000 toward the principal of the building loan.

## Annual Convention, October 12-14, 1965, Indianapolis

The committee discussed instituting a swearing-in ceremony for the incoming president, president-elect and councilors and the procedure was approved on motion of Drs. Rifner and Neumann.

A letter from the Florida Citrus Commission addressed to Dr. Jones offering to install a dispenser during the state convention for Florida orange juice, the orange juice to be purchased by the association, was read and the offer turned down by consent.

The offer of Parke, Davis & Company to install a large exhibit of paintings during the state convention was approved by consent.

A discussion on exhibit space for voluntary agencies was held and on motion by Drs. Olvey and Rifner, it was voted to offer exhibit space to voluntary agencies on the same basis as a technical exhibitor.

## Legislation

*National*—The status of Social Security to provide hospital and medical care was reviewed.

## Organization Matters

The matter previously discussed by the committee concerning advertising in the AMA publication for interns was again discussed and the secretary reported as a result of his inquiry to hospitals only two had replied as of this date. By consent, this matter was deferred until the next meeting to see if additional replies are received from hospitals.

A copy of a letter being circulated by Dr. James L. Doenges of Anderson was received and its contents noted.

Three letters from Dr. Norman Booher, as chairman of the Commission on Voluntary Health Agencies, were received, the first letter dealing with the previous action of the Executive Committee and Council concerning a letter of recognition being used by the commission was received for information. The second letter requested authority to purchase 16 copies of a booklet entitled "Viewpoints on State and Local Legislation Regulating Solicitation of Funds from the Public." Approval of the purchase was granted by consent. The third letter dealt with replacing Dr. James R. Mathews with Dr. Robert Acher as primary representative to the Core Committee of the Second National Conference on Cardiovascular Diseases. This was approved.

The secretary reviewed, for the information of the committee, the series of meetings and hearings involved in implementing the changes in the licensure law, as adopted by the last session of the legislature.

The secretary reviewed a letter which he had directed to the attorney general's office taking exception to their definition of "usual and customary fees."

A letter from Ralph O. Butz, M.D., of Muncie was read and upon motion of Dr. Neumann and taken by consent, was accepted.

The action of the Wisconsin Radiological Society informing third parties in Wisconsin, effective January 1, 1966, radiologists would bill their own fees was read for the information of the committee.

## Future Meetings

The Public Relations Institute to be held in Chicago, August 19-20. It was taken by consent that the staff should attend this meeting as well as the president, president-elect, chairman of the council and chairman of the Commission on Public Information.

By consent, the president and secretary were authorized to attend the Centennial Session of the Michigan State Medical Society.

There being no further business, the committee adjourned to meet again at 3:00 p.m. Saturday, September 11th, unless the chairman of the committee feels there is need for a meeting in the interim period.

# THE COUNCIL

July 18, 1965

The Council of the Indiana State Medical Association convened for its summer meeting at 9:00 a.m., Sunday, July 18, 1965, in the headquarters office, 3935 North Meridian Street, Indianapolis, with Dr. Eugene S. Rifner, the chairman, presiding.

Roll call showed the following present:

**Councilors:**

First District—P. J. V. Corcoran, Evansville
Second District—E. T. Edwards, Vincennes
Third District—Donald M. Kerr, Bedford
Fourth District—Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—A. W. Cavins, Terre Haute, alternate
Sixth District—William R. Tindall, Shelbyville
Seventh District—Albert M. Donato, Indianapolis
Eighth District—Donald R. Taylor, Muncie
Ninth District—Peter R. Petrich, Attica
Tenth District—Lowell H. Steen, Whiting
Lee Trachtenberg, Hammond, alternate
Eleventh District—Eugene S. Rifner, Van Buren
Lowell J. Hillis, Logansport, alternate
Twelfth District—Milton F. Popp, Fort Wayne
Thirteenth District—Jene R. Bennett, South Bend

**Officers:**

Joseph M. Black, Seymour, president
Kenneth O. Neumann, Lafayette, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer

**Journal:**

Frank B. Ramsey, Indianapolis, editor, *The Journal*

**Executive Committee:**

G. O. Larson, LaPorte, member

**Guests:**

Guy A. Owsley, Hartford City, AMA delegate
Harold C. Ochsner, Indianapolis, AMA delegate
William B. Challman, Mount Vernon, AMA alternate delegate
James H. Gosman, Indianapolis, AMA alternate delegate
Glenn W. Irwin, Jr., Indianapolis, dean, I. U. School of Medicine
A. C. Offutt, Indianapolis, State Health Commissioner
Lester D. Bibler, Indianapolis, AMA Trustee, and chairman, Student Loan Committee
William J. Stangle, Bloomington, Professional Advisory Committee, Blue Cross

**Staff:**

Robert J. Amick, field secretary
Howard Grindstaff, field secretary
Kenneth W. Bush, administrative assistant
J. A. Waggener, executive secretary

**By consent the minutes of the meeting held April 4, 1965, were approved as printed in the July, 1965 *Journal*.**

## Report of Councilors

The following district meetings were called to the attention of the Council:

District 11—Peru, September 15, 1965
District 13—South Bend, September 29, 1965

DR. POPP, Twelfth District, announced that Dr. William R. Clark, of Fort Wayne, had been re-elected as alternate councilor of the district for a three-year term, at the district's May meeting.

## Unfinished Business

1. *Legislative report.* **The following report of the Commission on Legislation, presented by Dr. Dwight W. Schuster, chairman, was accepted by consent:**

The Commission on Legislation suggests and requests this Council to authorize the president of the state medical association or individuals selected by him to:

1. Formulate and send letters to the Indiana congressional delegation pointing out the many dangers and potential pitfalls in Senate Bill 596, or House Bill 3140, and suggesting positive ideas whereby the bill would support and strengthen present patterns of patient care and doctor-patient relationships while bringing about further progress in medical education and research.

2. That the president, or others selected, at the earliest possible time hold discussions with:

(1) The Dean of the Indiana University Medical School.

(2) Representatives of the Indiana chapter of the American Academy of General Practice, the Indiana chapter of the American Society of Internal Medicine, the state medical association Commission on Aging, state medical association Commission on Medical Economics and the state medical association Commission on Medical Education.

(3) Mr. Frank Woolley or other American Medical Association representatives to learn detailed plans of the AMA regarding the above-mentioned bills.

(4) Representatives of any other group deemed to have interest in or to be of possible help in this type program, that is, S-596.

3. That following such discussions, any further ideas relative to amending or revising the present bills be forwarded to our Congressmen and to the AMA spokesman.

4. Further, that from the discussions, a semi-permanent group be formed to develop policies and plans for implementing in Indiana whatever bill is finally passed.

2. *Transfer of fees for radiology and pathology services from Blue Cross to Blue Shield.* The Council discussed the progress that had been made in

the transfer of fees for professional services from Blue Cross to Blue Shield.

**On motion of Drs. Steen and Edwards, the Council voted to request the Ad Hoc Committee for Blue Cross-Blue Shield Transfer to meet with the association attorneys and the opposing attorneys in order to bring this matter to a conclusion within a certain period of time, preferably by the time of the state convention, October 11-14.**

3. *Resolution on fees under federal medical programs.* **By consent, the Council adopted as official Council policy the following resolution on fees to be charged for medical care under programs financed by the federal government:**

Realignment of Physician Policy Re: Third Parties

WHEREAS, the physicians of this nation have advocated for generations constructive programs for the betterment of the public health; and,

WHEREAS, physicians have been responsible for the enactment of most of the laws in the interest of health; and,

WHEREAS, the longevity of our people has increased under present day medical care; and,

WHEREAS, physicians have, over the years, contributed their services either without charge to those in need when money was not available to pay for their services or at greatly reduced fees to provide the highest quality care for veterans, those on Old Age Assistance, and all other tax financed programs; and,

WHEREAS, in spite of the aforementioned charitable activities of physicians to relieve the needs of the sick on a gratuitous or semi-gratuitous basis and in spite of the pre-eminence of the nation's health care under our present fee for service system; and,

WHEREAS, there are those who now choose to impose a system of government dictated medical care, which the physicians have pointed out is dangerous from an economic and quality standpoint; and,

WHEREAS, the government now proposes to pay for the care of all over 65 regardless of need, under an increased tax program, eliminating the classification of needy cases but instead proposes to treat the needy and self-sufficient aged as equals;

NOW THEREFORE BE IT RESOLVED, that the physicians of this state adopt the same position for payment of their services as other purveyors of goods and services under federally supported programs; and,

BE IT FURTHER RESOLVED, that physicians inform all third parties that effective January 1, 1966, physicians will participate only on the basis they receive their usual and customary fee for like services as paid for by the private paying patients; and,

BE IT FURTHER RESOLVED, that usual and customary fees be defined as follows:

"*Usual*—The 'usual' fee is that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee).

"*Customary*—A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."

**On motion of Dr. Corcoran, duly seconded, put to vote, and carried, this resolution is to be submitted for consideration to the House of Delegates at the annual meeting.**

**On motion duly made, seconded, put to vote and carried, the Council instructed that a copy of this resolution be presented immediately to the presidents and chairmen of the welfare committees of each of the component county medical societies.**

4. *Annual Convention Program.* Dr. John Mader, chairman of the Convention Arrangements Committee, asked permission of the Council to place a representative of labor on the Medical-Socio-Economic Conference which will be held Thursday morning, October 14. **On motion duly made and seconded, this request was granted.**

## Reports of Officers

DR. JOSEPH M. BLACK, president: Mr. Chairman, members of the Council: I have a few things to bring to your attention. First, I want to thank the AMA delegates, the alternate delegates and all of the members of the association who attended the AMA meeting, for the work that they did and for their cooperation. I have received correspondence from Lester Bibler thanking us for our efforts in behalf of his re-election as AMA trustee.

Second, I am in the process of appointing reference committees for the state meeting in October. It is my thought, as a means of indoctrination of the alternate councilors into the functions of the state association, that perhaps they may be placed in the position of chairmen of the reference committees. Often the alternate councilors do not have the opportunity to really get into the workings of the association. Please let me have any suggestions you may have on this matter.

Dr. Black also called attention to the fact that in 1946 the Executive Committee, with the approval of the House of Delegates, investigated all malpractice insurance carriers and endorsed the St. Paul Mercury Company as the official carrier of malpractice insurance for members of the Indiana State Medical Association. Dr. Black also called attention to the ad in *The Journal* which conflicts with the opinion of the present Commission on Medical Economics and Insurance, report of which commission reads as follows:

> "In conclusion, this commission wishes to draw attention to the various association group insurance and investment plans which claim in their mail advertising to be approved by this commission. Such claims are untrue. We disapprove of this method of insurance or investment marketing, and it is our policy to give no favored position to any one company or any plan by granting approval, endorsement, or sanction, in any way whatsoever." (1964 report).

DR. BLACK: So I feel that we should notify the St. Paul Insurance Companies that we are not endorsing their malpractice insurance over any other company's. If you look back in your April *Journal*, this is what is stated, and I think it now is strictly against the policy of the Council and the state association. **(Dr. Neumann moved that this matter be brought to the attention of the House of Delegates at the October meeting for clarification or revision. Motion seconded by Dr. Edwards, put to vote and carried.)**

DR. BLACK: Last night I discussed, to the best of my ability to analyze the situation, a few of the legislative situations that have developed in Washington. I feel everything is not lost, and I still recommend to you that you go back home and contact your Congressman and Senators, expressing your opinions, with the hope that they will bring this to the attention of other conference committees. And recall to most of your Congressmen that all, or practically all of them, have made the statement in Indiana that they are opposed to socialized medicine. I feel that this is the one means that we can be effective. We cannot attack the whole bill but I think we have to spend our time developing pros and cons in various segments of the bill with its many amendments.

I would also like for you to go back home and encourage your men to attend the state association meeting in October. Basically, I think we have an interesting program from the standpoint of both the sections and the general meetings. Thank you.

DR. KENNETH O. NEUMANN, president-elect: Mr. Chairman, gentlemen: I have a few problems I'd like to mention. I mentioned one of these before, and this is in the area of commission appointments. We do have this rule about men being on commissions for two terms and there is some provision for putting on individuals for an at-large status for a limited term. I am hearing from some members of commissions who have expressed a desire to resign a commission provided certain individuals are retained on commissions. Now, I think this is most unfortunate. I personally don't know what the problem is; in many cases it seems that these commissions are not functioning as maybe we had intended them to. I have asked each of you to give me the names of individuals that you would recommend, and it is my intention to place these individuals on the various commissions in compliance with the Constitution and Bylaws. However, I would ask each of you to keep your ears open and try and give me information as to what seems to be going on in some of these commissions—whether this is a personality matter or what, I do not know, but it is going to be very difficult, I think, now and in the future, to get individuals to serve on these commissions if (1) the members either feel that the commission policy is coming from above down, rather than below up, and (2), if some of these personality conflicts continue. (This subject was discussed by several Council members.)

DR. NEUMANN: Well, I think we've gone on a premise that these commissions are really the heart blood of the organization and things must function through these, and I think this is our problem.

One other thing I think I should mention. I was going to bring this up this afternoon when the Blue Cross report comes in, but I think I'll mention it now. The thing that troubles me a great deal, and I think maybe it troubles Dr. Offutt too, but you all received and we discussed this several meetings back about the areawide regional hospital and health facilities planning. At the last meeting, the Blue Cross Board adopted this as a guide line for their rate committee and for their planning committee which, in essence, almost makes it mandatory for all hospitals, health facilities and what not, to participate in the areawide regional planning program which the Indiana Hospital Association implemented, or brought about. And it seems to me that it is not going to be too far off when there's going to be a direct conflict between this organization, Blue Cross, and this hospital association, and perhaps the State Board of Health, and some other things because there's a lot of meat in the fact that this committee is going to determine rates for hospitals after they've been expanded and developed. And I think you should be aware of the fact that this is the potential problem. We tried—at least I tried—to get the Board to defer action on this a little longer because I am sure a lot of the Board members hadn't really looked at it, and this makes an all-powerful set-up, but naturally, with the majority group on the Board not being physicians and being oriented towards hospitals, this was of no effect.

DR. FRANK B. RAMSEY, editor of *The Journal*: Dr. Rifner, members of the Council: *The Journal* is moving along in good style. Mr. Waggener got an advertising salesman to sell local and state advertising for our roster issue this year and he succeeded in selling almost a thousand dollars worth. He thinks he can do even better in the future. We are considering asking him to sell the same type of advertising for other issues of *The Journal* throughout the year.

Our total advertising pages are holding steady at 37 pages per issue.

The auditor's report for the nine-month period since last September shows that we have taken in 88% of the revenue which we expected to and that we have spent 70% of the money that we expected to spend. There's no indication on this report whether the three months of lame duck activities from September to January have been included in this report from last year, or have been subtracted from it for this year, but the indications from this report are that we are sailing along on an even budget.

In answer to a question, Dr. Ramsey discussed the offer of a neighboring journal for Indiana to become a part of a regional journal with the four states that border on Lake Michigan. The journal probably would be called the Lake Michigan Medical Journal. Dr. Ramsey reported that the Execu-

tive Committee had considered this proposition and had rejected it, on the basis that the Indiana *Journal* is doing well as it is now organized and therefore it is not interested in being a part of a regional journal.

Dr. Corcoran stated that from the standpoint of policy, matters such as this should be referred to the Committee of Business Consultants for *The Journal* from the Council.

DR. OTTIS N. OLVEY, treasurer: Mr. Chairman, members of the Council, guests: Actually, our financial status is pretty good. By the end of this year we should have somewhere around $4,000.00 surplus, perhaps more, perhaps less, depending upon some of the expenses that may come up. The General Fund report is:

| | |
|---|---|
| In checking account | $ 6,298.70 |
| Savings | 70,000.00 |
| Government bills | 76,435.31 |
| General Fund Securities | 60,000.00 |
| for a total of | $212,734.01 |

Our obligations are:

| | |
|---|---|
| Loan from Student Loan Fund | $ 15,000.00 |
| Fourth calendar quarter allocation | 49,436.58 |
| AMERF, Student Loan allocation, *Journal* 4th calendar quarter allocation | 46,084.00 |
| Total | $110,520.58 |
| Assets over liabilities total | $102,213.43 |

SUMMARY OF ALL FUNDS, as of June 30, 1965

| | | Total |
|---|---|---|
| *General Fund*: Cash | $ 6,298.70 | |
| Investment securities | 206,435.31 | $212,734.01 |
| *Journal Fund*: Cash | 5,733.22 | |
| Investment securities | 5,000.00 | 10,733.22 |
| *Medical Defense Fund*: Cash | 327.42 | |
| Investment securities | 35,000.00 | 35,327.42 |
| *Building Fund*: Cash | 3,887.57* | |
| Investment securities | 5,000.00 | 8,887.57 |
| *Student Loan Fund*: Cash | 2,465.03 | |
| Investment securities | 3,564.69 | 6,029.72 |
| *Kitchen Fund*: | | |
| Investment securities | 1,199.44 | 1,199.44 |
| Total cash | $ 18,711.94 | |
| Total investment securities | 256,199.44 | $274,911.38 |

* We are going to take $3,000.00 of the Building Fund and pay on our building obligation, which will bring our building loan down to $36,000.00.

**On motion duly made, seconded, put to vote, and carried, the report of the treasurer was accepted.**

*Report of AMA Delegates.* Drs. Owsley, Shields, Bibler and Ochsner discussed in detail the actions of the AMA House of Delegates at its meeting in New York in June. (For complete report, see pages 870-878, August, 1965, *Journal*).

**On motion of Drs. Popp and Steen, the Council, on roll call vote (8-7), agreed to implement Dr. Shields' recommendation that a policy meeting of the Council shall be held, on call of the Council chairman, with the AMA delegates just prior to each AMA meeting, that copies of all AMA resolutions shall be sent to each councilor and AMA delegate prior to this meeting and that the condensed, final report of the actions taken by the AMA House of Delegates shall be sent to each councilor. It was the consensus that these meetings shall be special, called, mandatory meetings for consideration only of matters to come before the AMA convention.**

AMA matters were further discussed by the secretary and Drs. Donato, Kerr, Bennett, Reid, Owsley, Popp, Challman, Edwards and Neumann.

A full discussion was had on non-participation in the medicare program, with Dr. Edwards recommending that a referendum be held, to reflect the exact sentiment of the entire state membership, if, in the opinion of the AMA delegates, this subject again will be an issue if a special AMA House of Delegates meeting is called. Dr. Black suggested that the membership should also be polled on Social Security. Dr. Petrich proposed that the Council establish a fairly reasonable unified definition of non-participation, to be given to the members.

**Dr. Edwards moved that a poll be conducted by the association, with haste, of the entire membership, on the questions of non-participation and Social Security for physicians, using the AMA's definition of non-participation. Motion seconded. Following discussion, Dr. Edwards withdrew the motion.**

**At the suggestion of the chairman of the Council, on motion duly made, seconded, put to vote, and carried, the Council instructed the AMA delegates to prepare resolutions on the matters which were referred by the AMA House of Delegates to the states for implementation, in order that the Council might present these resolutions to the Indiana House of Delegates, to be acted upon as the delegates may see fit.**

DR. LESTER D. BIBLER, member of the AMA Board of Trustees, thanked the members of the Council, the AMA delegates, the alternate delegates, and friends for their support in his reelection to the Board of Trustees, and gave a resumé of the actions of the board at the New York meeting, as follows:

(1) Plan for a meeting of the Executive Committee of the AMA and the American Hospital Association in Salt Lake City the second week in August.

(2) Changes in membership of AMA Council on Medical Education.

(3) Setting up of a committee on medical health services relative to a Commission on Mental Health Services for Children.

(4) AMA disability insurance program. The board determined that the program with Continental Casualty be continued, without change, until the end of the five-year period in September, 1967.

(5) Recommendation of American Society of Internal Medicine that AMA establish a joint commission for accreditation of health

benefit plans and programs. Action deferred.

(6) Legislative activities—SB-595 and HB-3141, entitled Health Professions Educational Assistance Amendments of '65, which would establish a scholarship program for medical and dental students, a national advisory council on medical education, and a new program of grants to medical and dental schools for construction. Board recommended that physicians follow these particular bills. The board opposed federal student loan program and voted support of the construction provisions.

Board recommended active support of HB-420, authorizing the commissioning of male nurses in the Army.

Supported HR-7484, recommending rank of Lieutenant General or Vice Admiral for Army, Navy and Air Force officers who serve as Surgeons General.

(7) Report on meeting of American Thrift Assembly, in Washington, April, 1965, was received as information. AMA will send a representative and observer to future meetings and report will be made to Board of Trustees.

(8) Objectives of the Peace Corps were endorsed by the Board of Trustees. The director of this organization seeks the guidance, advice and endorsement of the AMA in interesting physicians in serving in the Peace Corps.

(9) Joint Commission on Accreditation of Hospitals. Dr. L. O. Simenstad of Wisconsin elected to fill unexpired term of Dr. James Appel, who resigned.

(10) Osteopathy in medicine—resolution No. 7 relative to eligibility of physicians for internship and residency programs referred to board for action. Indiana Council should discuss suggestions on this resolution with Indiana delegates before interim meeting in Philadelphia in December.

(11) Nursing home accreditation. The board looked with favor on combining the accreditation of nursing homes and hospitals under the Joint Commission on Accreditation of Hospitals.

(12) Vacancy on Council on Medical Service.

(13) Approval of $1,000.00 appropriation to Judicial Council to sponsor essay contest among medical students.

Dr. Bibler called to the attention of the Council a pamphlet containing the various actions of the House of Delegates and committees and suggested that an outline of these proceedings be given to the councilors and the AMA delegates to peruse prior to the Philadelphia meeting in December.

**On motion of Dr. Popp, duly seconded, Dr. Guy A. Owsley was nominated for membership on the AMA Council on Medical Service.**

**On motion of Dr. Popp, taken by consent, greetings and best wishes for recovery were ordered sent from the Council to Dr. E. S. Jones, a patient in St. Margaret Hospital, Hammond.**

## Matters Referred to Council by Executive Committee

DR. G. O. LARSON, Executive Committee member, in the absence of Dr. Ralph Everly, chairman, presented the following matters:

(1) *Legal services to hospital staffs, component county medical societies and individual members through the ISMA legal counsel.* The Executive Committee recommends that services of the association attorneys be made available to county societies, hospital staffs and members of the association upon the basis that they pay for these services and that the attorneys confine their time to routine matters of the association.

Dr. Larson presented, as his personal opinion, for discussion by the Council, the thought that the association has an obligation to provide legal services and advice to the component societies and the present dues structure is adequate to include such services. A built-in protection exists at present wherein the state association is protected from abuse in that each individual case is and will continue to require the approval of the Executive Committee. The only reliable source of such aid is through the association attorney.

Dr. Larson recommended that no change be made in the present practice under which the association has been operating and that the Executive Committee, in preparing the budget for the next fiscal year, consider adjusting upward the retainer now paid the association attorneys.

Discussed by Drs. Corcoran, Kerr, Steen, Edwards, Neumann, Taylor and Popp.

**Dr. Edwards' motion that the state medical association continue to provide legal consultation for county medical societies and hospital medical staffs in those cases where the Executive Committee shall decide that this is pertinent to medical organization business, was duly seconded, put to vote and carried.**

**On motion of Drs. Edwards and Popp, the Executive Committee was authorized to negotiate a more realistic basis of remuneration for legal services to the association.**

(2) The second matter referred by the Executive Committee to the Council concerned a chiropractor's proposed research project in Elkhart county for the care of mentally deficient children. This matter was resolved by an explanation of the situation by Dr. Bennett and no Council action was necessary.

## Economic and Organization Matters

1. *Remission of state dues.* The Council voted remission of state dues as follows:

*Allen County*—one member because of retirement and removal from the state, on motion of Dr. Popp, duly seconded.

*Marion County*—two members, because of ill health, on motion of Dr. Donato, duly seconded.

2. *Trust Committee of Indiana Medical Education Foundation.* **Dr. Kerr moved that Dr. Maurice V. Kahler and Dr. Lawson J. Clark, both of Indianapolis, whose terms will expire October 31, 1965, be renominated. Motion lost for want of a second.**

**Dr. Petrich's motion to table the election of two members to the Trust Committee to succeed Drs. Kahler and Clark until the October Council meeting and to instruct the councilor from the Seventh District to present names of nominees for membership on this committee at the fall meeting was duly seconded, put to vote and carried.**

3. *District nominations for Blue Shield Board of Directors members for three-year terms ending March,* 1969, *were confirmed as follows:*

District 1—C. Philip Fox, Washington, General Surgeon

District 3—John M. Paris, New Albany, General Practice

District 6—Frank Green, Rushville, General Practice and Surgery

A report will be made from the Eleventh District following its meeting in September.

**In view of Dr. Walter U. Kennedy's long term of service with Blue Shield, it was taken by consent that the Council would recommend that Dr. Kennedy be carried as an honorary member of the Blue Shield Board.**

## New Business

1. *Better communication with membership.* Dr. Corcoran discussed the need for better communication among the membership in order that every member may be informed on the current problems and programs of the association. **Dr. Corcoran moved that each councilor attempt, between now and the October convention, to set up meetings with the delegates of the various county medical societies in his district, for a full discussion of these matters. Motion seconded by Dr. Kerr, put to vote and carried.**

2. *Relationships with doctors of osteopathy.* Dr. A. W. Ratcliffe, secretary of the Commission on Inter-Professional Relations, presented the following report, which was requested of the commission by the Council:

A considerable amount of background material is in our recommendation, which I feel is important in considering this, and, with your permission I would like to cover that.

Without attempting to go into ancient historical background concerning the relation between doctors of medicine and osteopaths, the commission feels particular attention should be called to the following significant references and developments:

In 1961 the Judicial Council reported to the AMA House of Delegates that the following significant events had occurred.

The American Hospital Association will now list hospitals having doctors of osteopathy on their medical staffs if the hospital submits evidence of regular care of the patient by the attending physician and of general supervision of the clinical work by doctors of medicine.

In September, 1960, the Joint Commission on Accreditation of Hospitals changed its policy to permit a hospital having an osteopath on its staff to apply for inspection for accreditation, provided it is listed by the American Hospital Association and provided, further, that it meets other eligibility requirements of the Joint Commission on Accreditation of Hospitals.

The AMA Judicial Council further stated its belief that the transition presently occurring within osteopathy should be recognized as evidence of an attempt by a significant number of practicing doctors of osteopathy to give their patients scientific medical care and, further, belief that this transition should be encouraged so that an inevitable, evolutionary process be expedited.

The Council recommended reappraisal of the AMA policy regarding relationships with doctors of osteopathy and that that policy should now be applied individually at a local level according to the facts as they exist.

They specifically recommend that the test now should be: does the individual doctor of osteopathy practice osteopathy or does he, in fact, practice a method of healing founded on a scientific basis? If he practices osteopathy, he practices a cult system of healing and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relations with him should be deemed ethical.

Finally, the AMA Council recommended that the several methods for evaluating the professional, ethical and scientific competence of practitioners of medicine can be used to evaluate the professional competence of doctors of osteopathy.

In October of 1961, the House of Delegates of the Indiana State Medical Association adopted a resolution that the Indiana State Medical Association go on record in declaring that consultation with osteopathic physicians is an accepted procedure in ethical medical practice when so determined at the local level,—that the doctor of osteopathy does, in fact, practice a system of healing founded on a scientific basis.

In 1963 the Judicial Council of the AMA again reported that since the 1961 pronouncement by the House of Delegates, action to permit the voluntary association of M.D.'s and D.O.'s has been taken in 15 state medical societies. In addition, a unification of the two professions has been effected in California. There's been some activity to change the prohibition against voluntary association of M.D.'s and D.O.'s in the following 8 states: Illinois, Indiana, Minnesota, New Hampshire, Vermont, Virginia, Washington and West Virginia. Almost 90% of the D.O.'s practice in the 38 states which grant unrestricted licenses to osteopaths. The tabulation appended to this same report shows 194 D.O.'s practicing in Indiana.

Now the specific recommendations from the commission for determining on a local level whether or not such an association would be ethical, which

was the question given to the commission, are as follows:

If the above background information is accepted and considered, it seems clear that no problem remains specifically regarding M.D., D.O. relationship. The problem which does remain is that of relationship between licensed physicians and service, not only as individual practitioners, but also as potential members of medical societies and hospital staffs. This is not a new problem, and there's long been regulations written and unwritten which are applicable to it. The commission suggests for consideration and amplification the following:

1. Referrals may be made to or accepted from fully licensed physicians.

2. Experience with such referrals should form a basis for judgment as to continuation of such association. Here to be considered are—

A. The quality of information received or supplied with the referral. This includes history, physical examination, laboratory and x-ray findings, tentative diagnosis and previous treatment.

B. Management of the case after return to the referring physician.

C. Results obtained.

It is to be kept in mind that any referral may and often does involve some educational responsibility on the part of the consultant to the referring physician.

Questions concerning hospital staff membership and privileges should be subject to the bylaws of the hospital medical staff. While these are no doubt somewhat varied, there is a fairly uniform and well-established pattern. It seems reasonable and desirable that they should require a minimum of one year internship and that department heads of the medical staff should hold an M.D. degree.

It further seems desirable that a specific privilege not be granted unless the candidate has some training and/or experience for it. It is generally accepted that the results of experience with any given procedure be subjected to continuing scrutiny by the staff organization and that sub-standard results be improved or the privilege revoked. This remains desirable.

I might add it is the hope of the commission that there will be elaboration or alteration as you see fit.

**On motion of Dr. Edwards, duly seconded, the Council accepted the report of the Commission on Inter-Professional Relations and referred it to the House of Delegates.**

3. *Recognition awards to be presented at the annual convention.* The secretary reported that the Commission on Public Information had been conducting a survey in the newspaper and communication industry and that commission will have a recommendation for an award in that particular area. **On motion of Dr. Steen, duly seconded, the Council voted that that recommendation and any other recommendations that may be made be referred to the Executive Committee for decision and implementation.**

**By consent this matter hereafter is to be placed on the agenda for the spring Council meeting in order that recommendations may be made at the summer Council meeting.**

4. *Grievance cases.* The Council, in its capacity as the Board of Censors of the association, had two grievance matters brought before it. Complainants were heard in both cases and were requested to submit in writing their complaints for further study by the Council.

5. **A resolution, passed by the Tippecanoe County Medical Society on April 13, 1965, entitled "Optional Blue Shield Coverage for M.D.'s" was approved by the Council on motion of Drs. Popp and Taylor and referred to the House of Delegates.**

6. *Eligibility regulations, ISMA group Blue Cross-Blue Shield policy.* A letter concerning this matter was received from Lloyd J. Banks, Enrollment Division, Blue Cross-Blue Shield.

**On motion, duly made, seconded, put to vote and carried, the Council approved of the following additions to the eligibility regulations:** (All regulations are listed; new regulations are marked by asterisks).

"A qualified physician may apply for and retain membership in the account established in the name of the Indiana State Medical Association provided he:

(a) Is licensed to practice medicine in Indiana

(b) Is a legal resident of the state of Indiana

(c) Is a member of the Indiana State Medical Association

(d) Applies for a membership on prescribed forms

(1) During the month of March each year

*(2) Within ninety (90) days following the date of being licensed to practice medicine in Indiana

*(3) Within ninety (90) days of beginning an active private practice

*(4) Within ninety (90) days following discharge from active military service."

7. *Creation of Commission on Rehabilitation.* **On motion duly made, seconded, put to vote, and carried, this matter was referred to the Executive Committee for discussion and consideration.** If the Executive Committee feels that this is a valid suggestion, it is authorized to prepare a resolution, in accordance with the Bylaws, which would create such a commission, for presentation to the House of Delegates.

## Reports of Guests

1. DR. A. C. OFFUTT, State Health Commissioner, spoke on the implementation of recent legislative action:

a. *The local Health Reorganization Bill* (Chapter 358, Acts of 1965), will become effective January 1, 1967. This is important because of the matter of fees which are in this bill.

b. *Independent living study* (Chapter 85, Acts of 1965). The sub-committee of the Legislative Advisory Commission has met and a format for the study is being developed at the State Board of Health. "We solicit your approval for the Indiana State Medical Association to cooperate with the State Board of Health in this study and your willingness to concern yourself with the format of the study and the appropriateness of this format."

**On motion of Dr. Edwards, duly seconded, the Council voted to cooperate with the State Board of Health in this study.**

c. *HR 6675, if and when it passes.* Dr. Offutt recommended that the State Medical Association support a program which will make it the responsibility of the State Board of Health to certify that the services provided in hospitals, nursing homes, and in any other health facility which may provide service under the act, meet established standards.

**On motion of Drs. Popp and Edwards, the Council voted to support the thesis that the State Board of Health is the appropriate agency to be utilized in administering the health care programs of HR 6675.**

Dr. Offutt also discussed the areawide planning program being conducted by the State Board of Health.

2. DR. WILLIAM J. STANGLE, Medical Advisory Committee of Blue Cross, reported on actions relating to Blue Cross which were taken by the AMA at its New York meeting in June:

(1) *Report C of the Council on Medical Service*—representatives on areawide planning agencies should be private rather than government associated physicians, and these physicians should represent non-government medical organizations.

(2) *Report D, Council on Medical Service,* relative to multiple insurance coverages. No recommendations were made; detailed report to come as soon as is feasible.

(3) *Resolution No.* 6—that Blue Shield fee should be paid only to private physicians and for services rendered to private physicians. The point at issue was whether Blue Shield fees should be paid for services of house officers in maximum service cases, that is, interns and residents.

(4) *Resolution No.* 17—AMA to take immediate steps to establish with other interested parties a Joint Commission for Voluntary Accreditation of Health Insurance Plans. A representative of the AMA Council on Medical Service pointed out that such a plan would be expensive and that great progress is being made under the present program. Resolution not adopted; recommended that CMS continue to work with various groups including the Blues and the National Association of Insurance Commission.

(5) *Resolution No.* 19—requested Board of Trustees to inform public of any inadequacies of coverage in national legislation and to caution those over 65 not to drop any present coverage that they may have. Referred to Board of Trustees.

(6) *Resolution No.* 26—concerning omission of payment for blood, blood derivatives and human tissues from insurance contracts sponsored by a medical society, not adopted as this was a duplication of a resolution passed in 1960.

(7) *Resolution No.* 60—professional courtesy to physicians. The action was to encourage physicians to carry voluntary health insurance for themselves and their dependents and to tender any benefits received to the attending physician when they were appropriate.

Dr. Stangle also reported that at the last Board of Directors meeting, he was appointed a member of the Rate Committee. "Operating costs are down for the first six months of 1965, from 4.35 to 3.93%. Cost per case is up a little—the hospital stay keeps creeping up. The average stay this year is 8.78 as compared to 8.67 a year ago. Average expense this year is $294.00 as against $280.00 last year."

In answer to Dr. Edwards' question relative to areawide planning and the fact that Blue Cross is going to use IHA mechanism instead of the State Board of Health, Dr. Stangle said: "As far as Blue Cross is concerned, it will work only with representatives of the local area, along with the state organization. Each hospital should designate membership, and, according with its special situation, basic membership should include representatives from its Board of Directors, its hospital administrator and the medical staff."

## Matters from Council Committees

1. *Council Liaison Committee with Blue Cross.* Dr. Donald R. Taylor, chairman, presented the following report:

"Most of this is redundant, but I might want to put it in a little different light, as I see it at least.

"First of all is the matter of a formal report. As we recommended at the April Council meeting, Dr. Stangle was appointed on this Rate Committee and has started to function.

"At the July meeting of the Blue Cross Board, as Dr. Stangle was discussing, there were several points of interest that I feel should be brought to the attention of the Council as a whole. Two of these are about approval of hospital expansion by Blue Cross and, specifically, the function that the rate committee will have in this picture.

"The first item, the Blue Cross board approved a committee recommendation outlining qualifications for Blue Cross participating hospitals based on an Indiana Hospital Association report called 'A Guiding Policy Statement on Hospital Long Range Planning and Development and Areawide Hospital and Related Facility Planning.'

"Now this statement, as I understand it, was developed by the Council on Health Facilities Planning. In this report they say that this council includes representatives from business, labor, medicine, health insurance, nursing homes and the State Board of Health. And we, about 18 months ago, refused to appoint a member to this council so that medicine does not have a representative on it, and I think Dr. Offutt stated that the State

Board of Health does not, so basically the Indiana State Hospital Association is the organization that has developed the statement and Blue Cross has accepted it as their guiding policy. To implement this, the Blue Cross board approved an amendment to Participating Hospital contracts as initially recommended by the Rate Committee as follows: 'The Participating Hospital agrees to notify Blue Cross in writing of any plans for major expansion of services or facilities at the earliest possible date.' Now this means that hospitals had better submit their plans and let Blue Cross approve them before starting any building or else they may not get their rates approved for the beds involved." (Discussed by Drs. Donato, Neumann and Edwards.)

Dr. Taylor continued: "I want to say that Dr. Neumann was the only individual who spoke against this policy. As I interpret his efforts, he tried to table the matter for further consideration, but the Blue Cross board voted it through.

"Another thing that happened at this meeting was that Blue Cross voted to donate $20,000 to the research program of the Indianapolis Hospital Development Association to study the effect of their nursing education programs in Indianapolis hospitals on the cost of patient care in these hospitals and how these costs might be transferred to the educational segment of the general economy. There is some background to this donation. This donation was prompted by the possibility that other insurance companies of Indianapolis might not participate in the fund raising activities of the Indianapolis hospitals unless Blue Cross also participated. Since Blue Cross by policy cannot contribute directly to hospital building funds, the above method was substituted in order to allow them to participate."

2. *Council Liaison Committee with Blue Shield.* Dr. Steen reported as follows:

(1) At its July meeting, the Blue Shield board voted not to commit Blue Shield for any funds for the research program of the Indianapolis Hospital Development Association.

(2) The board again proposed a psychiatric out-patient rider. The Psychiatric Association is working with Blue Shield on this.

(3) *Motors contract negotiations.* Some statements were made about these negotiations which, Dr. Steen said, he "had taken up vigorously with the people in Lake county principally concerned at this particular point. And I want to say again and emphasize it very vigorously, that Mr. Kilborn left the impression with the Motors people, and Mr. Twyman substantiates the fact that he left this impression, that Lake county had already agreed to accept Resolution No. 26 type payment, and that is contrary to the fact. And they will come to a very rude awakening on this point very shortly."

(4) The board discussed the matter of a package deal with a life insurance company to write both life and Blue Cross-Blue Shield health and accident insurance for small groups who at the present time cannot get this kind of coverage. "The board effectively took care of this matter through a couple of motions made by the directors."

Dr. Steen commented that much of the meeting time of the Blue Shield executive committee is spent in discussing problem claims.

3. *Council Liaison Committee with I.U. School of Medicine.* This committee has not met for some time. The chairman of the Council suggested that the president call a meeting in the near future.

## Miscellaneous

Dr. Steen asked for a definition of "non-participation" which he could use in conducting a poll of the physicians in his section of the state, to get their opinions on non-participation and social security for physicians. **(This was discussed by several, and it was agreed that Dr. Steen should formulate his own definition of non-participation).**

The chairman suggested that Dr. Corcoran put the remarks which he had made concerning organization, delegate apportionment and better communication with the county medical societies and the individual members, in writing for publication in *The Journal.*

There being no further business, the Council adjourned to meet again at 2:00 p.m., Monday, October 11, 1965, in Parlors B and C, Columbia Club, Indianapolis, providing a mandatory called meeting is not held earlier.

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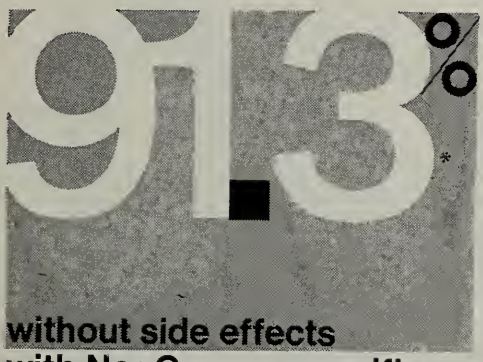
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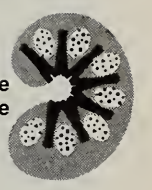



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| 1. | Eugene Austin, Evansville | R. E. Weitzel, Princeton | |
| 2. | C. Philip Fox, Washington | J. S. Brown, Carlisle | Washington, 1966 |
| 3. | Marion Hagan, French Lick | Arthur L. Wagner, Jasper | French Lick, 1966 |
| 4. | Merritt O. Alcorn, Madison | Francis W. Hare, Jr., Madison | Madison, 1966 |
| 5. | Robert M. Fell, Rosedale | J. W. Somerville, Clinton | |
| 6. | William E. Murray, New Castle | Paul M. Inlow, Shelbyville | Shelbyville, 1966 |
| 7. | William C. Stafford, Plainfield | James H. Gosman, Indianapolis | |
| 8. | Lowell Painter, Winchester | Paul W. Sparks, Winchester | Muncie, June 1, 1965 |
| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | May 19, 1966 |
| 10. | Michael Shellhouse, Gary | Edward J. Dierolf, Gary | Gary, Nov. 10, 1965 |
| 11. | Donald W. Ferrara, Peru | Max M. Earl, Kokomo | Kokomo, Sept. 21, 1966 |
| 12. | Warren L. Niccum, Columbia City | Kenneth F. Isenogle, Fort Wayne | May 18, 1966 |
| 13. | Guy B. Ingwell, Knox | Cecil R. Burket, Bremen | |



# The good life–just what the doctor ordered

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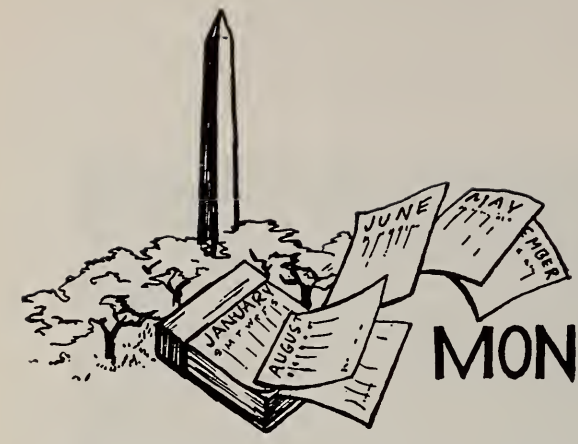
For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D. C.—Despite the flood of major health measures approved by Congress this year, President Johnson apparently plans to propose more important health legislation next year. Health has been given No. 1 priority on the "great society" program, it appears.

Johnson has been telling Congressmen to think in terms of even greater strides next year.

To lay the groundwork for new legislation, he has called a White House Conference on Health Nov. 3-4.

Johnson recently took the occasion of signing two health bills to outline his health goals:

—An increase in the average life expectancy from the present 70 years to 75 years.

—A reduction in infant mortality from the present rate of 25 deaths per 1,000 births to 16 per 1,000.

—Virtual elimination of polio, diphtheria and typhoid fever and an end to tuberculosis, measles and whooping cough.

—A reduction of 20% in deaths from heart disease, cancer and stroke—the so-called "killer diseases" that now account for one-third of all U.S. deaths.

—Elimination of death and disability among children caused by rheumatic fever and rheumatic heart disease.

—Eradication of malaria and cholera from the entire world.

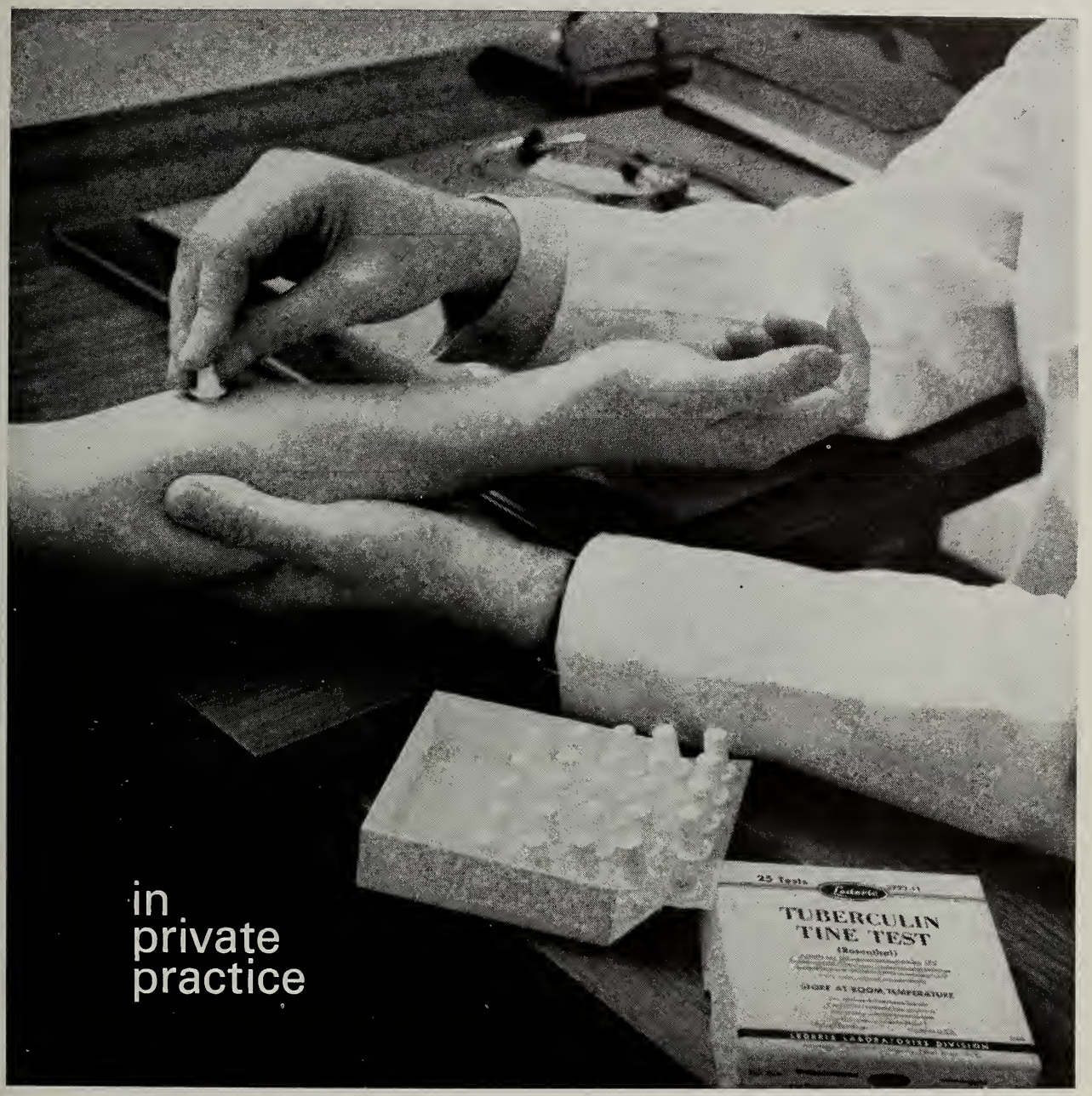
One of these two health bills he signed into law authorizes a three-year, $280 million extension of the Health Research Facilities Act. It also authorizes three additional assistant secretaries of HEW, one for health and medical affairs. A special assistant to the secretary had been the top official for health and medical affairs.

The other bill amends the Vaccination Assistance Act and extends it for five years. It authorizes Federal expenditures of $8 million a year, broadens the program to include measles and any other disease designated by the Surgeon General of the Public Health Service and makes the immunization program a continuing one, rather than "an intensive community vaccination (program) of limited duration." Expenditure of $45 million during the next five years also is authorized for family health clinics for migratory workers.

Neither the chairman nor the vice-chairman of the White House Conference on Health is a physician. However, five of the nine members of the executive committee to plan for the conference are physicians. All were appointed by Johnson.

George Beadle, Ph.D., president of the University of Chicago, will be

Continued




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**accurate**—comparable to the older standard intradermal tests

**practical**—can be administered by nurses under physician supervision

**convenient**—no refrigeration or other storage precautions

**economical**—stable for 2 years, self-contained disposable unit

Side effects are possible but very rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. *Available* as the new individually-capped unit, boxes of 5, or in cartons of 25.

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chairman and Boisfeuillet Jones, former special assistant to the HEW secretary, vice-chairman.

Physicians on the executive committee are Dwight L. Wilbur of San Francisco, a member of the Board of Trustees of AMA; George James, New York health commissioner; Lowell T. Coggeshall, trustee and former dean of the medical school, University of Chicago; Montague Cobb, professor of anatomy, Howard University Medical School and former president of the National Medical Association and Michael E. DeBakey, professor of surgery, Baylor University.

The chief executive said the purpose of the conference is to bring together "the best minds and the boldest ideas to deal with the pressing health needs of the nation." He said he hopes the conference will develop "creative programs that will bring better health to every American."

## FDA TRIES TO ELIMINATE CAUSES OF ILLNESS

The Food and Drug Administration issued two proposals designed to eliminate possible causes of illness. One called for a reduction in the amount of Vitamin D added to food products and the other for pasteurization of commerical egg products.

Last November, Dr. Robert Cooke of Johns Hopkins University expressed concern that the ingestion of excessive amounts of Vitamin D was a possible cause of infantile hypercalcemia. FDA Commissioner George P. Larrick then invited the Committee on Nutrition of the American Academy of Pediatrics and a joint Committee of the Council on Foods and Nutrition and the Council on Drugs of the American Medical Association to look into this problem.

Both committees recommended that, while there has been no positive demonstration of a cause and effect relationship of Vitamin D to this disease, there should be restrictions on the marketing of foods containing added Vitamin D.

The committee made clear that there is abundant scientific evidence to demonstrate that an excessive intake of Vitamin D is of no value and that 400 USP units per day will meet the full requirements of infants, children and nursing mothers.

Larrick concluded that "prudence" called on limiting the amount of the vitamins added to foods.

The proposal would permit the continued addition of Vitamin D to such foods as milk, milk products and infant formulas at a level of 400 USP units per quart. Over the counter Vitamin D preparations would be limited to a dosage of 400 USP units of Vitamin D per day. Vitamin D preparations containing over 400 USP units per day would be sold only on prescription. The proposal would deny authority for the addition of Vitamin D to standardized foods such as enriched flour, enriched cornmeal, enriched rice, enriched macaroni products, enriched bread and margarine.

Requiring pasteurization of commercial egg products was aimed at eliminating possible hazards to consumers from Salmonella bacteria in foods that contain eggs. During the past fiscal year, 220,150 pounds of egg products were seized for Salmonella contamination. Such products are used as ingredients in many other foods, including pre-mixed and ready-to-eat foods that the housewife uses. Egg products containing Salmonella have been implicated in cases of food-caused illness in man. ◄




**the sedentary life is often the seat of low back pain**

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

*The unusual muscle-relaxant and analgesic properties of 'Soma'* make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

*Indications:* 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

*Contraindications:* Allergic or idiosyncratic reactions to carisoprodol.

*Precautions:* 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

*Side Effects:* The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

*Dosage:* Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

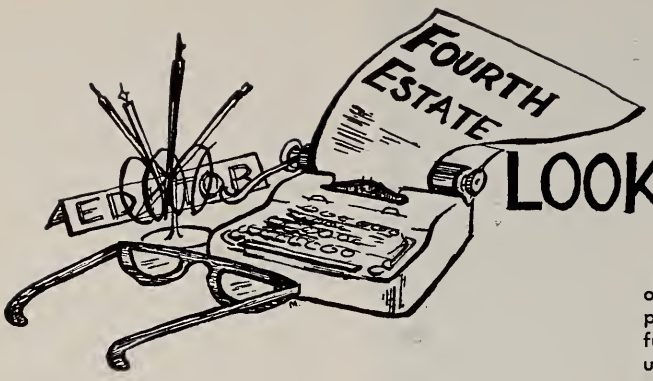
*Supplied:* Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

*Before prescribing, consult package circular.*

**for the relief of low back sprains and strains**

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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Headaches For Headachers

A highly regarded physician who specializes in headaches was complaining in a public address the other day that the biggest headaches doctors have nowadays are patients.

Patients, he lamented, know too much about medicine — or think they do — because they see and read so much about it.

"Two-thirds of the people," he said, "are not treated by doctors these days, but by television, radio, newspapers and magazines."

Patients are even listing their symptoms on paper, he revealed, and are bringing the list to the doctor along with the actual aches and pains.

"One man," he recalled with a shudder "brought in 88 pages in longhand, marked 'copy D'."

You can see what this could do to a doctor. There is no use popping an eight-syllable disease at a patient if the guy has already heard it on the air as a nine-syllable word. The impact is gone.

But here's an antidote for your headache, doctor:

At the same time people are learning more about medicine on television, they are also learning more about detergents, floor wax, household cleaners, dishpan hands, kissing-sweet breath, toothpaste, hair-sprays, beard softeners, coo-coo razor blades, higher-priced spreads, cigarette filters and beautiful beer.

In short, doctor, people are becoming more knowledgeable about almost everything.

It won't be long until the only person whose word really carries weight is the charming fellow or the glamorous gal on the television screen who is so persuasively pushing the product.

This may make it a little rough for a lot of people — but never, doctor, for a man who makes his living off of headaches. What do you think all these listeners are getting as they soak up all that gab?

Doctor, you've got it made. Happy headaching. —*Kendallville News-Sun*, July 16, 1965.

## Doctors See Socialized Medicine

The reaction of the American Medical Association to President Johnson's signing of the Medicare Bill was substantially that of the nearly 300 members of the Fort Wayne Medical Society — that Medicare is the opening wedge into socialized medicine.

Like the national organization, the Fort Wayne physicians fear the Medicare Act will result in the jamming of hospitals with persons who actually are not in need of hospitalization, as frequently has been the case in all countries where socialized medicine has been attempted.

All of Fort Wayne's three major hospitals have been busy. All have worked toward the enlargement of their buildings and facilities to meet the ever-increasing need. But Larry Pickering, executive secretary of the Medical Society here, points out that an undue and unnecessary but mandatory influx of patients under Medicare would lead to serious over-crowding, and that the programs in some cases could actually "lower the health care of the community as a whole."

In sharp contrast is the obviously over-optimistic declaration of President Johnson

Continued

# "I don't know what we would have done without Blue Cross Blue Shield."



As the hospital identification wrist band is snipped off, you think back on the long days of illness. And then's when many people say: "I don't know what we would have done without Blue Cross–Blue Shield."

For, you can't afford *not* to have Blue Cross–Blue Shield—with today's higher costs for medical miracles. More than a million and a half Hoosiers trust Blue Cross–Blue Shield to be there when needed, and with the finest health care benefits possible.

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Complete academic and therapy program for grades 7 through 12.

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The Readjustment Center
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Phone: (AC 313) 663-5522



## FOURTH ESTATE

Continued

at the ceremonial signing of the bill.

"No longer," said he, "will older Americans be denied the healing miracle of modern medicine."

There is, of course, little evidence that many "older Americans" have been denied needed medical care, since such care presently is extended at public expense to all unable to provide it for themselves. In reply to the President's statement, one newspaper states:

"The healing miracle is applied by human hands, by doctors and nurses, and it usually is applied in hospitals or convalescent homes. All these resources — the doctors and nurses and hospitals — are being used to capacity and to the point of exhaustion almost everywhere in America. Medicare will not produce one additional doctor, one additional nurse, nor one additional hospital, and the doctors believe it may discourage young people from training themselves for the healing profession."—*Ft. Wayne News Sentinel*, Aug. 7, 1965. ◄

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Meclizine HCl (25 mg.) and high $B_6$ content (50 mg.)

## Documented record of clinical safety

References: 1. Goldsmith, J. W.: Minn. Med. (Feb.) 1957. 2. Groskloss, H. H., Clancy, C. L., Healey, E. F., McCann, W. J., Maloney, F. D., Loritz, A. F.: Clinical Medicine (Sept.) 1955. 3. Codling, J. W., Lowden, R. J.: Northwest Med. (March) 1958. 4. Bethea, R. C.: International Record of Med. (May) 1960. 5. Lenz, W., Second International Conference on Congenital Malformations, N. Y., N. Y., (July) 1963.

Side effects: the incidence of drowsiness and other atropine-like effects is low. However, caution patients engaged in activities where alertness is mandatory.




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# Letters

## to the editor

17 June, 1965

To the Editor:

I was interested in your editorial note in your 57:12, 1964, edition regarding "Good Samaritan Laws" on p. 1365. You state: "The American Trial Lawyers and the American Medical Association have been interested in the frequency of lawsuits based on alleged malpractice at the scene of an accident. After exhaustive research, neither association has been able to find even one such suit. While there may be some justification for 'Good Samaritan' laws, there is no legal justification on the basis of recorded law suits."

I wish to tell you of my experience. Several years ago, I was called to a nearby supermarket by the management to see a customer who had fallen to the floor. I found this seventyish lady stretched out on the floor of the supermarket. She said she could get up. I couldn't do too much examination there; she didn't have the usual external rotation and shortening for a fracture of the neck of the femur. I suggested that she go to the hospital for further examination and x-rays. She refused all my suggestions; she wanted to go to a telephone and be taken to a town near Baltimore. Neither of these would I permit, and still she refused to follow my suggestions. Finally, in order to get her off the floor, we moved her to a chair beside her.

She finally agreed to go to a hospital where a fracture of the hip was diagnosed. The next day she was sent to a service hospital in the area and had surgery. She didn't get a good result, so she sued me, the assistant manager of the store, and the store itself (not the surgeon who operated). The case came to trial, the judge dismissed the case against the assistant manager and then the trial proceeded. I spent two days in court while the plaintiff presented its side of the case. Then my attorney asked for a "directed verdict" for me, which was granted. That got me off the hook, as it were, but defense by the store proceeded. The jury gave the plaintiff nothing.

I do not really know the definition of a "Good Samaritan" case. Usually one thinks of the accident on the street or highway in which a physician offers his services. If this is the correct definition, mine does not come under that category since I was actually called by the store. While mine may not be one, I am cured of anything like it in the future. I will not go out of my office to see an accident on a street or store except for a patient of mine.

Yours very truly,
Charles P. Ryland, M.D.
4400 - 49th Street, N. W.
Washington, D. C. 20016

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August 5, 1965

To the Editor:

I thought it might interest you to know we have a good supply of the leaflet, "The Ten Commandments for the Prevention of Alcoholism" which was excerpted from my paper PREVENTION OF ALCOHOLISM published last year. I would be happy to furnish copies, at no charge, to any of your readers who might wish to write for them.

With kind regards, I am

Sincerely,
William B. Terhune, M. D.
Silver Hill Foundation
The Terhune Clinic
New Canaan, Conn.

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September 10, 1965

To the Editor:

The anonymous article "Who Is To Blame," printed in the September, 1965 "News Flash," is so full of misstatements and half-truths that it seemed to merit some discussion.

In general the author seems to adopt the premise that all individuals have the total capacity of self-determination and an innate ability to exercise an independent free will in our present society. Although recognizing, he tends to deny and not understand the enormous impact which the num-

Continued

## to help relieve pain in common anorectal disorders

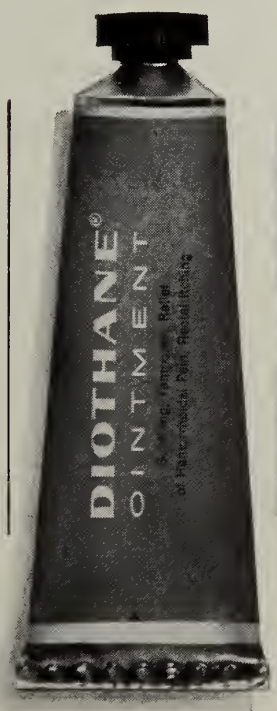
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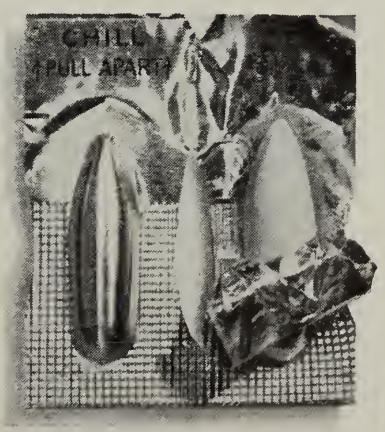
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erous social, economic and political forces have upon all individuals today.

He criticized the enlightened press and legal fraternity for trying to scientifically understand human motivation and behavior and the government for trying to take some practical measures to relieve stressed individuals. Above all he seemed to propose the ancient and utterly ineffectual punitive "woodshed" approach to solving all problems of overt acting-out against society.

The author revealed not only his own lack of understanding of such complex social behavior but also his resulting frustration and impatience with such behavior. He vividly revealed how his point of view is that of the old school of "inner-directed"[1] men living in a society of predominantly "other-directed" persons. This is, of course, exactly the reason why physicians, who are for the most part independent self-made "inner-directed" persons, are bridling at being treated as though they needed direction.

Such an article as "Who Is To Blame" would have been quite appropriate and well accepted 50 years ago, but is no longer realistically in time with our present society of organizations. For better or for worse, we have socially moved from the "Protestant Ethic"[2] which believed, "Whatever the embroidery, there is almost always the thought that pursuit of individual salvation through hard work, thrift and competitive struggle is the heart of the American achievement," toward the "Organization Man's" so-called "Social Ethic," which is, "—that contemporary body of thought which makes morally legitimate the pressures of society against the individual. It's major propositions are three: a belief in the group as the source of creativity; a belief in "belongingness" as the ultimate need of the individual; and a belief in the application of science to achieve the belongingness."

We as individual physicians are part of such organized society and recently have acted very much in an organized manner, more nearly following the beliefs of the "Social Ethic" than the older "Protestant Ethic." At the same time, paradoxically, many physicians are clinging to the rugged individualistic ideals of the "Protestant Ethic" rather than trying to make the transition to current realities of a very organized society. We cannot logically embrace both "ethics," and since we are in reality already "Organization Men," living in a society which is predominantly oriented toward organization structure, the wisest and most practical course is to adjust expeditiously to such a society in such a manner as to best further our joint goals.

Even small individual organizations nowadays are not as well-off as the merged giants. The medical profession has many splinter groups and since we were not a giant merger of such groups, our organization could not hope to challenge the greatest giant organization of them all, the government. Thinking thusly not only in organizations, but organized groups of smaller groups, one can readily see that a society run by and dominated by organizations is rather a "Who Is Responsible" than a "Who Is To Blame."

Byron Kilgore, M.D.
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Fort Wayne, Ind. ◄

1. David Riesman, "The Lonely Crowd."
2. William H. Whyte, Jr., *The Organization Man*, Simon & Schuster, Inc., 1956.

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# Cervical Spondylosis Simulating Amyotrophic Lateral Sclerosis

JAMES E. KEPLINGER, M.D.
West Lafayette, Ind.

CERVICAL intervertebral disc disease can cause a wide range of neurological signs and symptoms. The herniated cervical disc causing a brachial neuropathy with no other neurological involvement—a relatively common occurrence—has been given considerable emphasis in medical writings. This disorder is the so-called ruptured soft disc that presents posterolaterally and results in nerve root compression, generally involving only one nerve root.

Less emphasis, however, has been given to the neurological complications sometimes seen in association with chronic deterioration of more than one cervical disc—so-called cervical spondylosis.

Cervical spondylosis can cause neurological changes that assume almost perfectly the signs and symptoms of certain primary degenerative diseases of the central nervous system. The degenerative diseases in question are presently without effective treatment. They usually cause crippling neurological losses and some carry a hopeless prognosis. On the other hand, the distressing neurological complications of cervical spondylosis can at times be treated effectively. Proper diagnosis, then, is of critical importance.

The following case report illustrates that the neurological complications of cervical spondylosis can closely simulate amyotrophic lateral sclerosis.

## Case Report

A 60-year-old male, referred by Dr. Gilbert White of Whiting, Indiana, was admitted to the hospital on September 11, 1963. Perhaps a year or more before admission to the hospital, he had noticed mild shrinkage of the small muscles of the left hand. Later the small muscles of the right hand began to shrink. This was a mild, painless condition that did not cause him to seek medical attention.

He worked as a taxi cab driver until five weeks before admission to the hospital when he noticed steady and severe loss of strength in all extremities over the course of a few days. For a time he could walk by holding onto furniture and other things. Finally, a week before admission to the hospital, he was unable to walk and could not raise his arms to feed himself. There was no history of neck or arm pain; he was not aware of sensory loss in the hands or fingers, but complained of mild numbness in the soles of the feet. There was no history of impairment of bowel or bladder function. He had no difficulty in chewing or swallowing. There was no family history of a similar problem. His general health had been excellent.

## Physical Examination

The blood pressure was 134/80, pulse 80, temperature 98. The positive physical findings were limited to the nervous system. There was severe weakness of the extremi-



**FIGURE 1**
**HANDS show advanced atrophy of the dorsal interossei.**

ties. He could not walk or stand. In the supine position, he could barely flex his thighs and bend the knees; he could wiggle his toes slightly. The upper extremities were weaker than the lower ones. He could not raise either arm to the horizontal level. He could close his fingers but his grasp was not strong enough to hold a knife or fork. Extension and flexion of the forearms were weak. There was advanced atrophy of the small muscles of both hands (Figure 1). Apart from moderate wasting of the right supra and infraspinatus muscles, there was no evident atrophy of the shoulder girdle, arms or forearms. Fasciculations were prominent over both shoulders and arms.

No fasciculations were seen in the muscles of the legs. The right biceps reflex was absent; the left biceps reflex was normal. Both triceps and radial reflexes were present and equal. The knee and ankle jerks were moderately hyperactive. All superficial abdominal reflexes were absent. There were bilateral Babinski signs. Position sense was absent in the fingers and toes of the right extremities. Vibratory sense was present at the wrists but absent in the lower extremities.

Perception of pin prick and light touch was reduced in both legs from the knees downward. This was a symmetrical stocking-like, mild impairment of sensory perception. Similarly, there was a glove-like, mild reduction in light touch and pin prick perception over both hands and all the fingers. The cranial nerves were normal. The jaw jerk was not exaggerated. There was no limitation of neck motion.

*Laboratory*: The routine blood and urine tests were normal. The spinal fluid was clear and colorless. It contained one polymorphonuclear leukocyte per cubic millimeter of fluid and 40 milligrams percent protein.

*X-ray*: Plain x-ray films of the cervical spine showed marked narrowing of the intervertebral disc space between the fifth and sixth and sixth and seventh cervical vertebrae. Anterior and posterior spur formations were prominent on the fourth, fifth and sixth cervical vertebrae.

A cervical myelogram showed nearly complete obstruction of the flow of pantopaque at the level of the fourth cervical



**FIGURE 2**
**MYELOGRAM shows nearly complete block of the intraspinal canal at level of fourth cervical intervertebral disc.**

intervertebral disc (Figure 2).

*Operation*: On September 22, a laminectomy of the third, fourth and fifth cervical vertebrae was made. There were moderate hypertrophic changes in the laminae. Bony ridges on the ventral surface of the intraspinal canal were present at each of the exposed intervertebral disc levels. These ridges obviously encroached upon the intraspinal canal. There was an especially prominent ridge at the level of the fourth intervertebral disc. Laterally, at the uncovertebral joints, calcified spurs impinged upon the nerve roots on both sides.

Curettes were used to remove this tissue and foraminal decompressions were made at all the exposed levels. On opening the dura mater, focal arachnoiditis was found overlying the spinal cord at the level of the fourth cervical disc. Filmy arachnoid adhesions bridging from the surface of the cord to the dura mater were divided. The dentate ligaments were cut on both sides. At the conclusion of the procedure, the cord was mobile.

### Hospital Course

Immediately after surgery, there was

slight increase in weakness of the right leg and both arms. There was no change in the sensory examination. After the first postoperative week, he showed slow but steady improvement. He received intensive physical therapy. By the tenth postoperative day, he could open and close the fingers of both hands. He could draw up and extend both legs.

One month after operation there was much improvement. He could walk several feet without assistance, although he dragged the right leg a little and that leg was generally weaker than the left one. The grip of the right hand was good and he had no trouble eating with that hand. He could open and close the fingers of both hands well enough to button his clothes. Fasciculations continued in the right shoulder and arm. Fasciculations disappeared from the left shoulder and arm.

Six months after the operation, the patient could walk well without a cane although he still favored the right leg. He was able to raise both hands over his head; the grip was good in both hands. He had no trouble dressing himself or eating. There was less atrophy of the scapular muscles. There was also an increase in volume of the interosseous muscles of the right hand. All fasciculations had disappeared except for an occasional flicker in the right triceps muscle.

## Discussion

The patient's preoperative clinical course was, at first glance, quite in keeping with a diagnosis of amyotrophic lateral sclerosis. A patient with amyotrophic lateral sclerosis is commonly middle-aged or older, as was our patient. An association of painless wasting and weakness of the small muscles of the hands with widespread fasciculations is typical of amyotrophic lateral sclerosis. Although objective sensory changes are not a part of amyotrophic lateral sclerosis, many patients with this disease initially complain of numbness of the hands or feet. Our patient had noticed numbness of his feet. Since amyotrophic laternal sclerosis involves both upper and lower motor neurones, it is common to find increased tendon reflexes and Babinski signs in the lower extremities. These neurological changes were present in our patient.

Certain neurological findings in our patient were not, however, in keeping with a diagnosis of amyotrophic lateral sclerosis. The patient showed objective sensory changes in his hands and feet. The tendon reflexes in the upper extremities were not exaggerated—as they almost invariably are with upper motor neurone disease—and the right biceps reflex was, in fact, absent. Although amyotrophic lateral sclerosis generally has a downward course, the decline is usually steady and moderately slow. Our patient developed profound weakness of all extremities in the course of a few days. He showed no bulbar signs or symptoms, as is so often found with amyotrophic lateral sclerosis.

The focal arachnoiditis at the level of the fourth cervical intervertebral disc doubtless impaired the function of the corticospinal tracts and was probably the main cause of weakness in both the upper and lower extremities. The presence of arachnoiditis could also explain the rapidity with which severe weakness developed. The calcified ridges ventral to the spinal cord may have aggravated cord impairment and perhaps were responsible for the development of arachnoid adhesions.

The atrophy in the upper extremities—and part of the weakness of those extremities—resulted from nerve root compression at more than one level. Although atrophy of the interossei and lumbricals is generally held to be due to involvement of the eighth cervical and first thoracic nerve roots, neither the plain spine x-ray films nor the myelogram showed evidence of encroachment at the formina of those nerves. Others have observed poor correlation between the site of the lesions (as determined by x-ray study and operation) and the distribution of muscular wasting.[1] Perhaps this is partially explained by the fact that anterior rootlets and anterior horn cells of a given spinal nerve arise from cord segments situated higher than the point of foraminal exit of the mixed spinal nerve.[2]

A relative absence of sensory changes, despite prominent motor loss, is a common

clinical feature of the so-called amyotrophic syndrome associated with cervical spondylosis. A plausible explanation for this, as emphasized by Kahn,[3] is that on compression of a peripheral nerve, the fibers are affected according to their size. Probably this relationship also applies on compression of the spinal cord. Therefore, the larger fibers conducting motor impulses, vibratory and touch sense, are the first to be impaired while the small fibers conducting pain and temperature may be entirely spared.

The relative absence of radicular pain and muscle spasm (in the amyotrophic syndrome due to cervical spondylosis) despite, in most instances, marked bony compression of mixed spinal nerves, is yet unexplained. This contrasts sharply with the painful brachial neuropathy so typical of an acute herniated disc syndrome.

Any combination of nervous structures (spinal cord and peripheral nerves) in the cervical area may be involved in cervical spondylosis. Accordingly, cervical spondylosis can simulate a number of conditions of the central nervous system other than amyotrophic lateral sclerosis, viz., multiple sclerosis, subacute combined degeneration, syringomyelia, cervical cord neoplasm and various entrapment syndromes of the median and ulnar nerves. [1,4]

In some instances, the cardinal signs of a given degenerative disease of the nervous system are plainly evident and proper diagnosis is no problem. But more often, the diagnosis is not plainly evident and it is here that a myelogram is of crucial importance.


## Summary

Cervical spondylosis can simulate amyotrophic lateral sclerosis. Proper diagnosis rests on a careful examination of the intraspinal canal by myelography.


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# Attempted Suicide in the Aged

JACK W. HICKMAN, M.D.*
*Indianapolis*

THE INCIDENCE of suicide attempts tends to increase with advancing years up to a given point; however, the following case presentation demonstrates a rather unusual aspect of attempted suicide in the very old. It is rare for patients such as the one described here, who have attained the age of 90, to make suicide attempts. A review of several hundred suicide attempts from the records of Marion County General Hospital revealed only three similar cases in the past 14 years.

### Case Report

The patient, a 90-year-old white male was brought to Marion County General Hospital on May 3, 1964, by hospital ambulance after a call from the Indianapolis Police Department. The patient had been found in a garage with the power lawnmower motor running and the doors closed. He had been discovered by his wife who pulled him from the garage and notified the police.

The patient had generally been in good health considering his advanced years. In 1958, laryngectomy had been performed at another hospital for carcinoma of the larynx. He made a fine recovery and recent follow-up visits had shown no signs of recurrence. In recent months he noted failing vision and had been told that this was due to cataracts. The patient sought no further help regarding the cataracts and made no inquiries regarding corrective surgery.

Past history revealed a prostatectomy for benign prostatic hypertrophy 20 years previously and a right inguinal hernia repair in 1949. Review of systems was otherwise non-revealing. The patient had been somewhat depressed in recent months over his failing vision and had expressed concern to his wife and friends that he was afraid that he would become a burden on his wife. The patient's financial status was such that he and his wife were comfortably settled and did not have large outstanding debts. A note was discovered at home saying that he did not wish to become a burden and asking forgiveness for what he was about to do.

Physical examination revealed a 90-year-old white male who was moderately sluggish on admission but responded fairly well to questioning. Blood pressure was 140/80, pulse was 120 and irregular, respirations were 20 per minute. The patient appeared approximately 10-15 years younger than his stated age. Positive points on physical examination included bilateral lens opacities of a moderately advanced degree which made examination of the optic fundi impossible. There was no nuchal rigidity. A permanent tracheostomy tube was in place. Lung excursions were equal and no rales, rhonchi or dullness were noted. No cardiomegaly was noted. Heart tones were clear and sharp without murmurs; the rhythm was irregular.

Examination of the abdomen was completely normal. Examination of the extremities revealed no clubbing, cyanosis or edema. The patient was able to move all four extremities and neurological examination was normal. Hemoglobin was 15.0 grams %, white blood count was 9,350 with a normal differential, urinalysis was negative, VDRL was negative, blood sugar was 96 mgm. %, BUN was 22 mgms. %, electrolytes were within normal limits and a PA chest film was interpreted as being essentially normal. EKG showed right bundle branch block and atrial fibrillation. The patient was treated with supportive intravenous fluids and 100% oxygen by nasal catheter.

Four hours after admission, the patient was fully alert, conscious and was recovering satisfactorily. He was willing to talk quite freely about his suicide attempt, but with moderate remorse.

Psychiatric consultation was obtained, and it was the consultant's opinion that the patient was fully oriented and alert without

* Director of Medical Education, Marion County General Hospital; Assistant Professor of Internal Medicine, Indiana University School of Medicine.

gross impairment in memory or judgment. No symptomology suggestive of major organic brain syndrome was elicited. The patient was judged not to be psychotic and it was thought that long-term psychiatric follow-up would not be necessary. A consultation was obtained from the ophthalmology department, and the diagnosis of mature cataracts was confirmed. The patient was told of the possibility of surgery for this condition which would greatly improve his vision. With this advice, the patient showed a marked elevation of mood and behavior and eagerly consented to surgery. Consequently, cataract extraction with full sector iridectomy of the left eye was performed on May 16, 1964. The patient tolerated the procedure well. The resultant increase in visual acuity has been gratefully accepted by the patient, and he now feels as if he has a new life ahead of him.

Three somewhat similar suicide attempts were discovered in the records of Marion County General Hospital since 1950.

*Case #2*: This case involved a 76-year-old white female who was brought to the hospital in 1956 with her husband. It was thought at that time that the couple had been overcome accidentally by gas from the stove. The wife showed early signs of vascular collapse, but she recovered satisfactorily. However, her husband died. The patient was not seen again until 1961 when she came to the receiving ward after again being overcome by gas. This time it was judged to be a definite suicide attempt because a farewell note had been discovered at the home. This, of course, raised the question whether the initial episode in 1956 was, in fact, a husband-and-wife suicide pact.

*Case #3*: An 84-year-old white male was brought to the receiving ward in 1953 in a semicomatose condition after having been found in a locked garage with his car running. A note was discovered which requested that his brother be informed in case he died. This patient had been deaf for some years and was recently widowed. He recovered satisfactorily and was released to the custody of his brother after psychiatric consultation revealed that he was safe for discharge.

*Case #4*: This case of an 82-year-old white male is somewhat similar to Case #2 in that this patient was brought to the receiving ward in 1953 with his wife and again accidental exposure to illuminating gas fumes was thought to be the cause. The patient's wife died during this admission, but the patient recovered and was discharged to the care of other relatives after appropriate psychiatric consultation.

## Discussion

It has been estimated that there are approximately 20,000 successful suicide attempts in the United States annually,[5] and this estimate is probably low since many attempts at suicide are disguised to appear as accidental deaths.[2,6] In reviewing a number of large series of studies on suicides, none was found to contain an attempted suicide in a patient as old as the one described in this article. Also, statistics concerning patients as old as the present one are somewhat misleading. There were only 6,310 people in Indiana and 215,204 in the entire United States who were 90 years of age and over at the time of the 1960 census.[10] Only two suicides per state per year would therefore give an incidence of roughly 42 per 100,000 population in this age group.

The following table[9] illustrates the rising trend for suicides with advanced years in the population.

SUICIDE RATES PER 100,000 FOR THE U.S.

| Age | Male | Female |
|---|---|---|
| 20-24 | 9.1 | 2.6 |
| 30-34 | 14.3 | 5.2 |
| 40-44 | 22.4 | 7.0 |
| 50-54 | 32.0 | 8.5 |
| 60-64 | 37.5 | 9.4 |
| 70-74 | 47.6 | 6.6 |
| 80-84 | 60.7 | 5.0 |
| over 85 | 56.9 | 4.3 |

It has been recognized that failing health and especially failing eyesight or fear of potentially fatal illness may serve as precipitating causes for suicide attempts.[1] By the same token, however, it is very clear that even in a "normal" psychiatric popu-

lation, a high percentage of people at least have fleeting thoughts of suicide at one time or another. It is interesting that in our case, the patient tolerated successfully a surgical procedure that involved carcinoma of the larynx with its moderately mutilating surgical procedure and the necessary tracheostomy cannula. Yet it was not at the time of this major illness that he attempted suicide, but some years later when his failing vision made it appear as if he would be a burden on his wife. The patient's admission to this hospital in May of 1964 occurred during the time of the year when the highest number of suicide attempts occur, (most suicide attempts in this country being undertaken in April and May). The rate for suicide attempts is higher in the widowed and divorced segments of the population.[4]

In most reviews of suicide attempts, it is stated that at least one-third and usually as high as one-half of the patients have major organic brain syndrome and that two-thirds of the patients in one series had major illnesses threatening their lives at the time that suicide was attempted.[8,9] It is interesting that, as with our patient, there may not be a gross abnormality of behavior leading up to the act and that most people who attempt suicide are considered abnormal only in retrospect. Only about one suicide attempt in six is successful,[3] and there is some disagreement whether the aged who may suffer from organic psychotic reaction are necessarily increased risks for suicide attempts.[7] Despite the suicide precautions that are taken in most hospitals, it does not necessarily follow that patients who are admitted as suicide attempts will make a suicide attempt while in the hospital. If it is at all possible to judge which population group are potential suicide risks, the following circumstances can alert the physician to this possibility:

1. Development of either depression or agitation by the patient for some time prior to the attempt.
2. Hypochondriasis and the preoccupation with either symptoms of a minor nature or imaginary symptoms.
3. The tendency to be withdrawn and downcast coupled with a rejection of attempts by the family to console him.
4. Physical symptoms such as constipation, insomnia or decreased libido.
5. Advancing years, particularly as retirement begins without planned activities to take the place of the active participation in business, especially in the widowed or divorced group.
6. The development of major organic illness that may be of a life-threatening nature and/or require mutilating surgery for treatment.
7. Development of suggestive clinical signs or organic brain disease.
8. Development of failing eyesight and the person's worry about becoming dependent upon his loved ones.

## Summary

A suicide attempt in a 90-year-old white male is described. The patient's fear of impending blindness and dependency upon his wife seems to be the main precipitating cause for this attempt. The extreme advanced years of this patient makes it somewhat unusual; however, the precipitating causes in this case are those that are frequently seen in other cases. Early factors that may alert the physician to suicide attempts in patients are discussed.

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September 13, 1965

Mr. James A. Waggener, Executive Secretary
Indiana State Medical Association
3935 N. Meridian St.
Indianapolis, Ind.

Dear Mr. Waggener:

This is in reply to your letter of September 1, 1965, concerning Public Law 89-97, the "Social Security Amendments of 1965."

Although self-employed physicians are now covered retroactively to January 1, 1965, they need not pay any Social Security taxes until next year when they file their income tax returns for 1965. Self-employed individuals compute their self-employment tax on Schedule C-3, Form 1040. When computing an estimated income tax return, a physician need not include his estimated self-employment tax for Social Security purposes.

A doctor who attains 65 before 1968 would be eligible for the hospital insurance benefits but not monthly cash benefits if he is insured for the first time retroactively to January 1, 1965. The Act provides for quarters of coverage, as you know, and a self-employed individual is credited with four quarters of coverage for every year in which he reports that he had net earnings of $400 or more from covered self-employment.

The "transitional insured status" provisions of the 1965 Amendments provide that a person attaining 65 before 1968 may qualify for hospital insurance benefits with a minimum of six quarters of coverage, but do not disturb existing provisions which require 16 quarters of coverage for entitlement to monthly cash benefits.

Physicians who are 76 years of age (73 if female) or older, if they report $400 or more as net earnings from self-employment in 1965, can qualify this year for a monthly cash benefit of $35.00 under the "transitional insured status" provisions for such individuals need only three quarters of coverage. A 75-year-old male (72 years female) needs four quarters of coverage to qualify this year for the special $35.00 benefit.

We expect a comprehensive article in *JAMA* soon on Social Security benefits. Do not hesitate, however, to write us again if we can be of any assistance to you in handling inquiries.

Sincerely,

Nick G. Onychuk
American Medical Association

# The Case of Bill Bum, the Burbling Bursitic

ARNOLD LIEBERMAN, M.D.
New York, N.Y.



A GENTLE GUSH of water bubbles or burbles. The bards burble that the brooks babble. Do bulging bursae bubble? Or — is it the patient who burbles?

Onomatopoeic prattling may amuse the mind; rarely is it relevant to serious writing. As proof of the exception, let us examine the problems raised by — shall we call him Bill Bum.

In the recent past, the Four Horsemen of the Apocalypse were ever present. Death, plagues, warfare and famine were accepted as being in the nature of things. In the slums of London, mothers gave their babes gin in their bottles because milk was too expensive. Millions perished in the great Irish famine; the charitable Queen Victoria and her nobles continued gourmandizing in all placidity, indeed. In this century, a renowned American financier proclaimed, "The Public be damned." During the Depression, many doctors still in practice today, yours truly included, remember babies swollen with hunger edema. Kwashiorkor still stalks vast areas of the world. It was F.D.R. who appealed to the national conscience to help "the one-third of the Nation, ill-fed, ill-clothed, ill-housed."

Public relief came to the fore. We developed federal, state and municipal agencies to cope with these situations. There is today a vast bureaucracy to administer the distribution of the tax-gathered, multi-billions of dollars. In New York City alone, in this year of 1965, the municipal budget has allocated a hefty one-half billion plus dollars for this one single item!

Aren't we sort of overdoing things? Are we going back to the Roman days of "panem et circenses" — free food and amusement — for the degenerate, debauched Roman proletariat? Should public welfare be a vehicle for raising the recipients standards above penury levels and tiding him over until better days? Or — should it reward indolence and depravity? Should we encourage the total immorality of teenage mothers being subsidized with extra gratuities every time they drop a baby of varying and uncertain fatherhood?*

There is a great deal of snide discussion anent socialized medicine and the reactionary, self-serving doctors impeding

* See *Reader's Digest*, April, 1965, p. 66, Judge Juanita Stout.

"progress." To these detractors, "psychiatry" has become "mental hygiene"; a drunk is a "compulsive ethanolic." Well! Do-gooders notwithstanding, we doctors do encounter many instances of patients who do *NOT* want to get well as long as they are *PAID* to stay sick. Also, services that — when rendered — cost the recipient nothing are (more often than not) accepted at just that valuation.

### An Illiterate Innominate

But to get back to our friend, Bill Bum. Undeniably, he had been born — or "birthed," to use the mountaineering lingo, in a remote "holler" of West Virginia; probably, the time was in the middle twenties. We cannot be more exact as all involved were total illiterates and no county clerk was informed of the event.

Bill has a very hazy memory of moving with his folks "down-a-ways" to a cluster of houses around a busy coal mine tipple. For a while, the place even boasted a grocery. This closed (along with the mine) in the "Big Depression." Apparently, no one in authority was aware of the plight of these mountaineers. Want and naked hunger stalked the remote reaches of this land. Bill's parents died; an uncle took in the orphan.

That gentleman eked out a living of sorts by running a still for "mountain dew." Bill recollects being one of the children keeping a lookout for "Feds": incomprehensible enemies to be avoided at all costs.

A little later, a main highway came through the valley below. Jobs became available at gas stations. Bill picked up enough practical know-how to make himself useful as a truck driver assistant. As he became a teen-ager and then matured, he became a husky, handsome youth. He began "sparking" with the opposite sex; at an extremely early age he married. An itinerant preacher performed the rites; again, no official file recorded the ceremony. By the happenstance of such judicious avoidance of written records, Bill became a "no such" person. During World War II, he drove increasing distances as a trucker assistant: he loaded and unloaded freight and spelled the driver. Uncle Sam continued to be unaware of his existence. Bill received no




"Greetings" asking him to become a tourist in uniform.

While Bill had never received any formal schooling, he did learn to sign his name, recognize road signs and even to spell out instructions for auto maintenance and similar such essentials. Also, by doing things that come naturally, he began to father a brood of his own.

### An Accident Brings Affluence

Some of Bill's trips would take him clear into New York City. One day, while in the metropolis, he had the chore of unloading a heavy cargo of crates. A passing motorist misjudged the double parked truck. Even as Bill was swinging a heavy box down from the top of the stack, the car just flicked our friend's elbow. The auto never stopped or even slowed; the container came down flat upon Bill's bending knee as he crashed backwards sprawling supine upon the pavement. Temporarily, he must have been knocked unconscious; anyway, his next memory was of being on the ward of a municipal hospital.

Apart from the concussion, the severest damage appeared to have been inflicted around the knee. The heavy box had bruised the joint badly; the tissues were black and blue and horribly swollen. X-rays were all

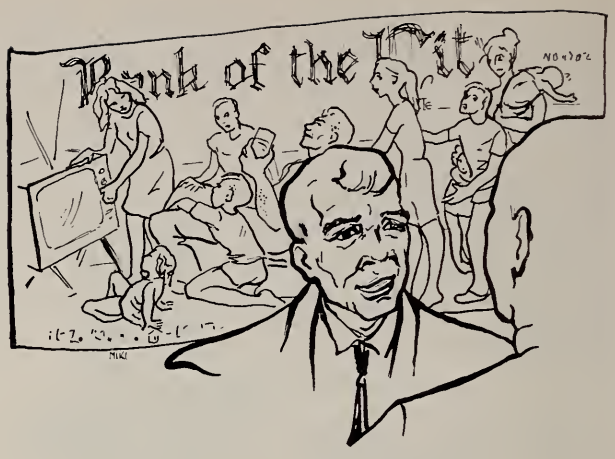
negative and no sutures were needed. Bill lay in the hospital for weeks and weeks recuperating. The knee was hugely distended; in particular, the suprapatellar bursa filled and refilled with fluid: at first, bloody, then, ever more clear with each aspiration.

The record shows that some of the orthopods considered surgery. They wanted to inspect directly for items such as torn cartilages, frayed tendons, displaced fat pads and joint mice. However, this was not done. Expectant and symptomatic therapy gave excellent results. Physiotherapy in the form of transducer heat, massages and exercises finally had Bill up and around. Being young and otherwise quite healthy, even the knee (when free of fluid) regained its full range of motion.

The agent of the company for which Bill had been working arranged to have the entire family brought to New York. Bill received disability pay; as a bonus, he was able to establish a bona-fide New York address. Soon he was well enough to be discharged to the OPD of the hospital. While an invalid, he continued to draw compensation money; also, the municipal Department of Welfare entered into the picture, helping to pay some of the household bills. The transplanted family settled into a very placid existence. Their incredibly squalid background made indoor plumbing, electric light, television and radio a veritable heaven, indeed! Symbols of bliss undreamed of back in their Appalachian "holler!"

### A Bounty for a Bursa

Gradually, Bill recovered full use of his body, i.e., all but that trick knee. Ah, the knee: The suprapatellar bursa continued to refill with the clear fluid; the bi-weekly tap became the accepted norm. There was just enough disability to prevent Bill from going back to his duties as a trucker's assistant. In New York City, Bill could not go hunting, fishing or even help brew that "mountain dew." But he *could* loll at home, listen to the radio, watch TV, sip beer — and, of course — continue to beget children. Between compensation *AND* welfare, the family acquired a vested right in a standard of living far surpassing their previous scramble for a bare, precarious level of marginal subsistence.




And so a whole *DECADE* slid by. There came the day when I was asked to see Bill in consultation at the OPD clinic. The frustrated orthopods had come — finally — to the conclusion that an exploration of the knee joint was the only solution to the baffling enigma of the constantly refilling bursa. We reviewed the entire case together. All x-rays were serenely normal; all conceivable laboratory tests, ditto. Repeated, painstaking physical examinations had shown only the obvious suprapatellar bursitis. The knee joint itself was perfectly stable; it was completely capable of the exact range of motion to be expected in this largest hinge joint of the body. Of course, whenever the bursa became distended with fluid, even walking produced a limp.

As 90% of suprapatellar bursae have direct communication with the knee joint itself, it was just possible that the bursitic fluid represented merely an overflow. However, the surgeons surmised that the original trauma might have produced adhesions which sealed the bursa from the rest of the knee. After all, that heavy crate had come crashing down precisely on the area underlaid by the suprapatellar bursa. Very possibly, the tendon of the quadriceps was also still suffering from the force that had compressed it. The orthopods expected to make incisions paralleling the tendon. They wanted to expose the bursal sac and dissect it free of the surrounding tissues. They would then be able to determine the condition of the quadriceps tendon: did it need a plastic repair? Then, they could also open the bursal sac and establish the fact as to whether it did or did not communicate with

the main knee joint itself.

The surgeons were of the considered opinion that they would have to do just a simple exploration and a synovectomy. Of course, this would be only a very minor operation. Even if it turned out that the knee joint itself would require exploration, the chances of a poor result would still be most remote. If the incisions were extended to open the joint, direct inspection would answer such queries as: were the menisscuses damaged? Were the fat pads involved? In what physical state were the surrounding tendons and ligaments?

The lengthy exposition was summarized by the chief orthopedic surgeon stating that — in his opinion — the operation would be confined to the excision of the suprapatellar bursa alone; it would take only an half hour or so. Nevertheless, it was my duty to perform a meticulous physical examination of this husky specimen of most virile manhood. First, I stood by and watched the resident withdraw some five ounces of the clear bubbly fluid from the bursa. An extremely careful use of the usual and unusual tests revealed the expected: no abnormalities whatever. I put in writing what had been rather obvious from the start: there could be no medical objections to the contemplated operation.

Rather earnestly, speaking for the gathered group of doctors, I informed our friend that — while no honest physician could give him an absolute guarantee — Bill could have every expectation of becoming again 100% fit: able to resume the heaviest physical labors.

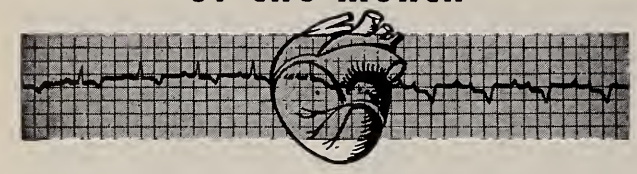
### Crux Criticorum

Denizens of Appalachia, descendants of our pioneer forefathers, have been renowned these many years for their sturdy independence, self-reliance and love of freedom. Our friend, Bill had, however, been tasting the fleshpots of the big city for far too long. His reply was indignant and almost disarming, "But, Doc: My wife and *eleven* children get me a monthly check of $975.00! Where can I get a job that will pay me half as much? Do you think I'm going to let you take away my disability?"

Bill the Bum, THE BURBLING BURSITIC, had unanswerable (even if heretical) logic on his side. He could not be forced to undergo the operation. Long philosophical tirades would be ridiculously pointless. Yet: one of my administrative hats requires me to review welfare cases and make recommendations. Will I be a reactionary fuddy-duddy if I make brief note of the facts just outlined? The original will go to the department of welfare; a carbon will go to the compensation board. Does *SOCIETY* owe Bill the Bum a *duty* to re-educate him? To channel his thinking away from the degeneration into the obligatory parasite that he had become? Can he ever become again a useful citizen? What do I have to spell out? Was it *only* Bill's fault that he had become a bum? ◄

1270 Fifth Ave.
New York, N. Y.

# Electrocardiogram
## of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Posterior Myocardial Infarction*

*CHARLES FISCH, M.D.*
*Indianapolis*

THE conventional electrocardiogram leads are capable of exploring the diaphragmatic (Leads II, III, AVF), the anterior and lateral aspects of the heart (I, AVL, V1-V6). As yet there is no convenient way to explore directly the posterior wall of the heart, other than with an esophageal electrode. Consequently, the hallmark of myocardial infarction, namely a Q wave, is not recorded in cases of pure posterior infarction. The ECG changes of posterior infarction are largely those of "reciprocal" QRS changes due to the loss of the posterior myocardium. This change is an increase in height of the QRS recorded from the opposite wall (V1-V3). In other words the loss of the posteriorly directed forces leaves the QRS forces in V1-V3 unopposed, resulting in increase in height of the R wave in V1-V3. Figures 1 and 2 are examples of posterior wall infarction.

ECG taken on 9-9-64 is normal (Figure 1). The tracing recorded on 9-30-64 demonstrates classical changes of a diaphragmatic-apical infarction (Q waves and S-T changes in I, II, III, AVF, V5, V6). The loss of posterior myocardium is shown by the appearance of tall R waves in $V4_R$ and V1. This change indicates loss of the electrical forces from the opposing wall, in this instance the posterior wall. Similarly the appearance of a tall R in AVR is due to loss of opposing forces, in this case the diaphragmatic surface.

The second tracing (Figure 2) shows the characteristic changes of an isolated lateral wall infarction (Q and T wave changes in I, AVL, V6). The loss of the posteriorly directed forces (posterior myocardial infarction) is manifested by a tall R in V1 and V2.

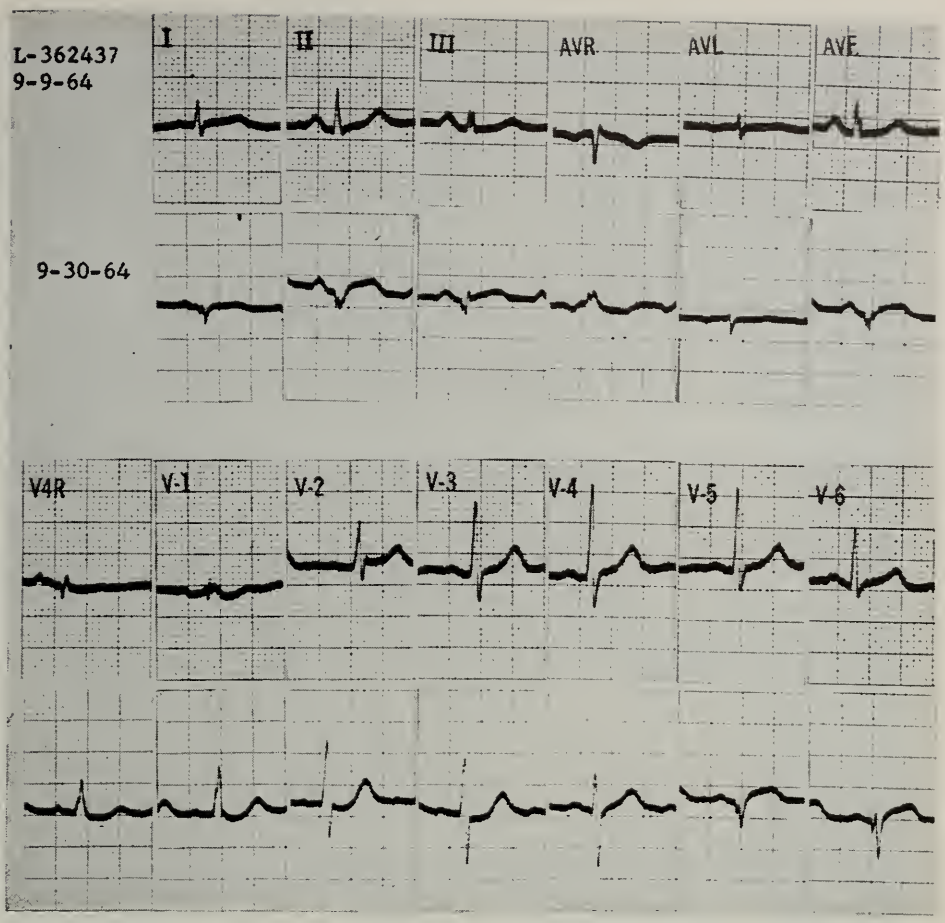



**FIGURE 1**
CONTROL tracing on 9-9-64 showing a normal ECG. Tracing taken on 9-30-64 shows a diaphragmatic-apical, as well as a true posterior infarction.

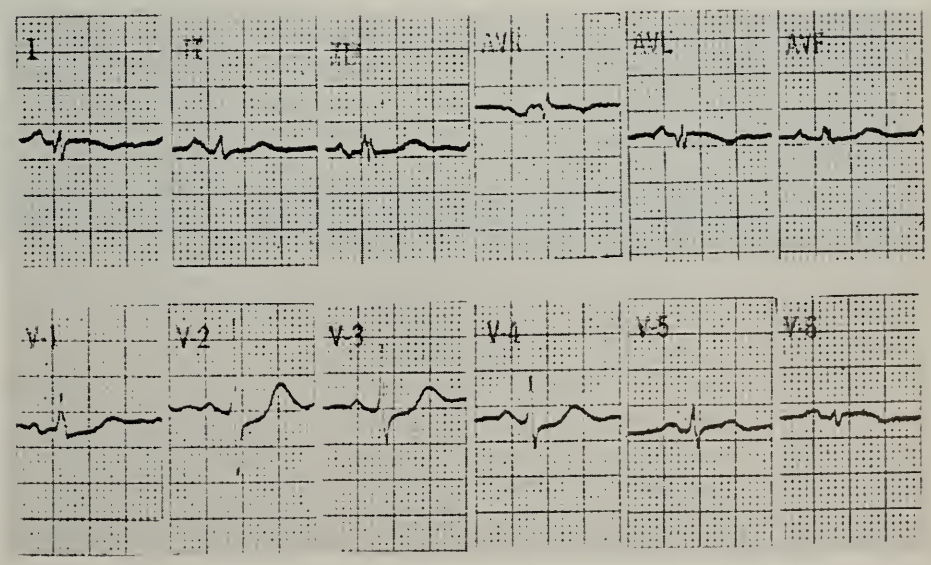



**FIGURE 2**
THIS tracing shows a localized lateral or apical as well as a true posterior infarction.

# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Gastrocolic Fistulas Secondary To a Benign Gastric Ulcer

*ERICH K. LANG, M.D.**
*Indianapolis*

A 52-year-old white female was admitted with a history of massive diarrhea and severe weight loss for the past four months. For the past year, the patient had noted intermittent black tarry stools, vague abdominal pain and gradual weight loss. Physical examination at the time of admission revealed an emaciated white female weighing 92 pounds. The skin turgor was poor. Her hemoglobin was 9.6 grams. Examination of the stool revealed undigested components of both vegetable and meat fibers.

An upper GI series demonstrated a huge lesser curvature gastric ulcer, measuring 4cms. across its base (Figure 1). Barium passed immediately into the descending colon and a gastrocolic fistula had apparently developed. The margin of the huge ulcer crater showed heaped-up edges. The ulcer, however, appeared to be deeply penetrating. The appearance of the heaped-up edges suggested either marked edema or possibly malignant degeneration. The penetrating characteristics favored a benign ulcer.

An exploratory operation was done and the gastrocolic fistula was closed. Multiple biopsies around the margins of the ulcer crater were taken. All of these showed inflammatory reaction. The appearance was typical of a benign gastric ulcer of huge size. The patient continued to do poorly in the immediate postoperative phase and despite supportive therapy, expired on the sixth postoperative day. Autopsy revealed an adequate closure of the gastrocolic fistula and only very little peritoneal reaction to the recent operative procedure. The death was attributed to electrolyte imbalance, severe cachexia and markedly abnormal serum protein levels. Careful scrutiny of lymph nodes in the retroperitoneal space failed to reveal any evidence of tumor.

### Discussion

Gastrocolic fistulas are commonly seen with extensive carcinoma of either the stomach or the colon, resulting in transfixation of the other structure and formation of a gastrocolic fistula. However, the formation of a gastrocolic fistula, secondary to a benign gastric ulcer as illustrated in this case is considered a rarity. If recognized early, the treatment is simple and consists of closure of the fistula.

* Department of Radiology, Methodist Hospital, Indianapolis.

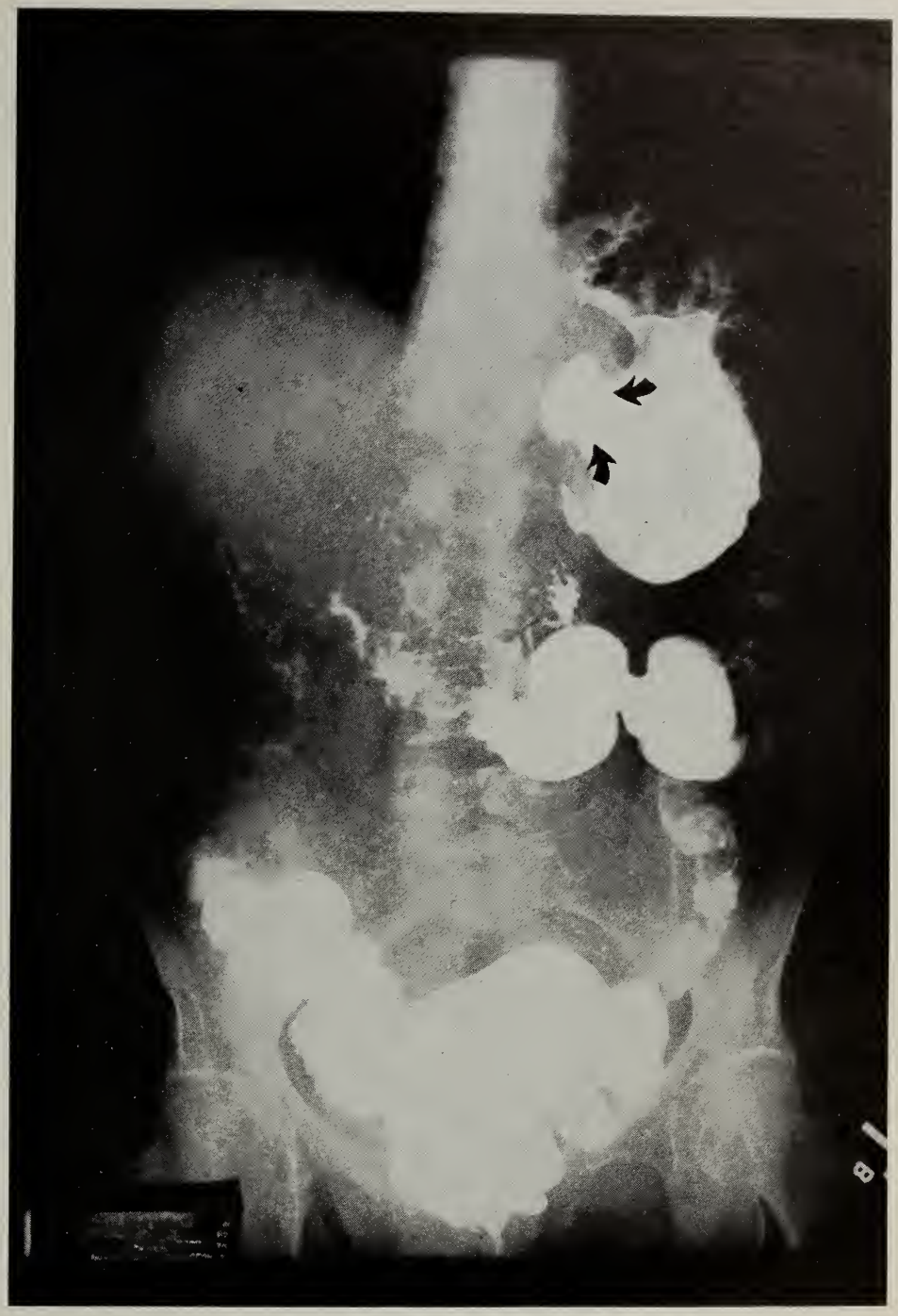
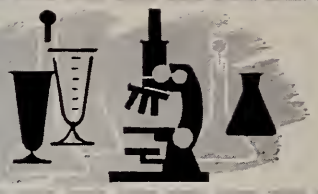


**FIGURE 1**

**NOTE the huge ulcer crater, measuring more than 4cms. along its base and deeply penetrating. The heaped-up margins of either side of the ulcer crater are felt to be secondary to indurated inflammatory tissue. Most of the barium progressed immediately into the descending colon. Only a small amount of the barium is identifiable in the duodenum.**

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



**This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon I. Blum, M.D., Terre Haute.**

# *Differential Diagnosis of the Month:* HYPERADRENALISM

*WEI-PING LOH, M.D.**
*Gary*

| | |
|---|---|
| *Clinical data*: | A 48-year-old woman was admitted because of hypertension, change of body contour and progressive weakness of several month's duration. She also had been under treatment for diabetes. |
| *Physical examination*: | Moon-like and plethoric face. Obesity with hump of fat on the back of her neck. Skin thin and abdomen bulging. Blood pressure: 160/110. Other findings less remarkable. |
| *Laboratory data*: | Hemoglobin: 16 gms. (cyanmethemoglobin method), hematocrit: 50, and white blood count: 12,000 with decrease in lymphocytes and absence of eosinophils.<br>Eosinophil count: 25/cu.mm. (normal: 100-300).<br>Urine: one plus sugar, a few white blood cells.<br>Urinary 17-ketosteroids: 30 mg./24 hrs. (normal: 5-15).<br>Urinary 17-OH-corticosteroids: 18 mg./24 hrs. (normal: 2-8).<br>Plasma cortisol: increased.<br>X-ray studies: osteoporosis of lumbar spine and a suggestive mass above left kidney. |
| *Consultation and follow-up*: | A pathologist was consulted and he explained the laboratory findings on the basis of Cushing's syndrome due to hyperadrenalism. In order to differentiate between adrenal hyperplasia and adrenal tumor, he recommended Dexamethasone supression test. After Dexamethasone, the eosinophil count remained low and the urinary 17-ketosteroids, 17-OH-corticosteroids and plasma cortisol all remained abnormally high. A tumor of the left adrenal was suspected. On removal, the tumor was found to be an adrenal cortical carcinoma without metastasis. All abnormal findings disappeared after the operation. |

* Chief Pathologist, Methodist Hospital of Gary; Assistant Professor of Pathology, Chicago Medical School.

*Interpretation*: The initial abnormal findings pointed to overactivity of the adrenal cortex. In order to differentiate between adrenal cortical hyperplasia and adrenal cortical tumor, one may find the following table useful.

HYPERADRENALISM

| Test | Baseline | After ACTH* | | After Dexamethasone** | |
|---|---|---|---|---|---|
| | | Hyperplasia | Tumor | Hyperplasia | Tumor |
| Eosinophil count | ↓ | ↓ | ↓ | → or ↑ | ↓ |
| 17-ketosteroids (urine) | ↑ | ↑ ↑ ↑ | ↑ ↑ | → or ↓ | ↑ |
| 17-OH-corticosteroids (urine) | ↑ | ↑ ↑ ↑ | ↑ ↑ | → or ↓ | ↑ |
| Cortisol (plasma) | ↑ | ↑ ↑ ↑ | ↑ ↑ | → or ↓ | ↑ |

↓ : decrease → : normal ↑ : increase

The number of arrows indicates the degree of change.
* ACTH: 80 units (gel) per day, IM, for two successive days.
* *Dexamethasone: 2 mg. qid., for two days.

The above table indicates that an adrenal tumor (neoplasm) is relatively independent of the effect of drugs, either ACTH or Dexamethasone. On the other hand, adrenal hyperplasia is much more sensitive to drug effects. This difference provides a basis for the differential tests.

## About Our Cover

Diabetes is dangerous or serious *only* when it remains undiagnosed.

The normal day-to-day search for new patients harboring unsuspected diabetes will be intensified again this year by observance of Diabetes Week November 14 to 20.

Thousands of persons who have no idea they have diabetes mellitus are discovered each year during this special week. It is said that there are always as many unknown diabetics as there are known ones.

The American Diabetes Association and its member associations at the state, county and local levels throughout the United States have organized a program designed to educate the lay public regarding diabetes and its significance.

Yet it remains the physician's job to detect the unknown cases and begin the life-saving treatment.

It is not too late for any physician to obtain "Dreypak" diabetes test strips at a nominal cost for free distribution to patients during diabetes week. "Dreypak" units, information and assistance are available upon request from the American Diabetes Association, Inc., 1 East 45th St., New York 17.

A detection drive of this magnitude needs the cooperation of every Indiana physician to make it successful.

Our thanks to the American Diabetes Association for making its "check list" poster available to us for this month's cover.—J.F.S.

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

*Devoted to the interests of the medical profession of Indiana*

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# Diabetes Detection Week

THE Annual Diabetes Detection Drive will be conducted next month during the week preceding the week of Thanksgiving.

The giving of thanks will be entirely appropriate for all who take advantage of the occasion to have a test for glycosuria. Those with negative findings will be reassured by this one indication of good health.

Those with positive tests who later are found to have diabetes will not be elated at first, but will later give thanks for having discovered they have the disease. It pays large dividends to those who detect it in an early and nonsymptomatic stage and apply proper treatment.

There are still approximately as many unknown as known diabetic people. Any action taken to encourage the diagnosis of diabetes soon after its onset contributes a great service to the patient.

The Diabetes Association in conjunction with the county medical societies of Indiana and the Indiana State Medical Association is enlisting the cooperation of all public spirited organizations, voluntary, commercial and educational, to make the simple test for glycosuria available to as many people as possible.

## *Guest Editorials*

# The Coggeshall Report

AN URGENT APPEAL for bold, far-reaching and rapid changes in American medical education was sounded today in a report prepared for the Association of American Medical Colleges.

The rising expectations for health care —both quantitatively and qualitatively— present a challenge to medical education in America that must be met within the institutional setting of the university, with the assistance of both public and private agencies at every level, the report said.

The 107-page report is titled "Planning for Medical Progress Through Education." It was submitted to the Executive Council of the Association of American Medical Colleges at the headquarters in Evanston, Illinois.

Dr. Lowell T. Coggeshall, Vice-President for Special Assignments and a Trustee of the University of Chicago was chairman of a seven-man committee which developed the recommendations after a one-year study financed by the John and Mary R. Markle Foundation and the Commonwealth Foundation, both of New York City.

Other members of the committee were:

Dr. William N. Hubbard, Dean, the University of Michigan Medical School, Ann Arbor, who served as vice-chairman.

Dr. Michael DeBakey, Professor of Surgery, Baylor University College of Medicine, Houston, Texas.

Dr. John E. Deitrick, Dean, Cornell University Medical College, New York City.

Dr. Clark Kerr, President of the University of California, Berkeley.

Dr. George A. Perera, Professor of Medicine and Associate Dean, College of Physicians and Surgeons, Columbia University, New York City.

Dr. Ward Darley, Consultant to the Executive Director, Association of American Medical Colleges, Denver.

Dr. Robert C. Berson, now Executive Director, AAMC, Evanston, Illinois and Washington, D.C.; formerly Dean, University of Texas, South Texas Medical School, San Antonio.

One of the significant recommendations of the report is for broader utilization by physicians and surgeons of the "team approach" in caring for the nation's health. It said, in part:

"The idea of self-sufficient independence has historically been characteristic of the physician. Medical education has been a leader in establishing standards that have been widely emulated in the related health professions, with each seeking analogous independence.

"However the rise of specialization and the rapid decline in numbers of general practitioners has resulted inevitably in an increasing tendency toward team practice involving the contribution of various specialists.

As specialization increases, so does the need for coordination of the 'team' that is essential to care for the patient. The team that requires coordination includes both physicians with a variety of specialties and an ever-increasing number of allied health personnel with competence to perform more routine technical tasks. The physician's knowledge can no longer encompass the details of all procedures performed by other members of the team. These developments require the attending physicians to be a 'coordinator' or 'team leader' of a team that collaborates to meet the needs of the patient."

On the increased use of a "team approach" to health care, the report went on to say:

"There is no clear alternative to the organization of the modern practice of medicine as a team effort—and the doctor must be trained specifically to function as leader of the team. Teamwork is mandatory in most activities of the modern world—industry, communications, education—and it should not be impossible in the health sciences. The team leader, if he is to maintain his leadership, must recognize his responsibilities and be prepared to meet them.

"The team approach is manifesting itself in the hospital, the clinic, the many kinds of group practices that have come into use in the past half century. There is every likelihood that the team approach to health care will expand in use in decades ahead and that teams will become larger, more comprehensive in the range of skills included and more complex in structure. This will further advance the institutionalization of health care and it has profound implications for the education of all persons entering medicine and the other health professions and occupations."

In the introduction to the report, the committee said that advances in medicine have been more significant and rapid during the past half century than in any previous period of human history. "The pace has increased especially during the past two decades," the committee noted. "The brilliance of recent advances and the vast potential for future advances make it impossible for even the best informed persons in the field of medicine to predict with accuracy the gains that can be made to the benefit of mankind in the years to come."

The report pointed out that President Lyndon B. Johnson, in his recent message to Congress, said that greatness requires not only an educated people but also a healthy people and set matching the achievements of medicine to the afflictions of its people as one of the goals of the nation.

The report went on:

"It is increasingly clear that medical advances and changing health expectations are stimulating unparalled changes in society. As the conditions of society change, the institutions that serve society should keep pace. This is a relationship of reciprocal influence, since society itself is strongly molded by its institutions. Nowhere is this reciprocal relationship more evident than in the field of health."

On receiving the report, Dr. George A. Wolf, Jr., President of the AAMC, said:

"This thoughtful report by Dr. Coggeshall and his eminent colleagues on the committee may well prove to be the most significant in the field of American medical education since the issuance in 1910 of the report of the late Abraham Flexner. The Flexner Report stimulated a renaissance in medical education. Then, as now, the vantage point for directing the efficient and proper use of the nation's medical resources was seen as being situated in the universities. It would be my hope that the leaders of American medical education will find it possible to implement most, if not all, of its recommendations as expeditiously as possible."

At the time of the Flexner Report, there were approximately 150 medical schools in the United States; "the majority were privately owned and there was little disposition for their proprietors to seek affiliation with larger educational organizations. . . . In 1965, of the 99 medical schools in operation or authorized to admit students in the near future, all but nine have some degree of affiliation with universities," the report said.

The report called for a strengthening of relationships between the AAMC and institutions of higher learning in the United States concerned with training men and women for the health professions. Specifically, the report observed:

". . . Progress in medical science can only be made by viewing research and instruction as inextricably intertwined.

"To a major degree, instruction and research are not separate terms at all. Research has become an instrument not only for obtaining new knowledge but for teaching and learning and medical students increasingly are being integrated into research activities as a regular part of their laboratory and classroom assignments. . . .

"Interdisciplinary approaches to instruction and research can be taken best—and, probably, only—within the jurisdiction of the university. . . .

"Closer ties among the sciences and closer ties—virtual identity—between research and instruction highlight the need for further development of the relationship between the medical school and the university emphasized by Flexner a half-century ago."

In his letter transmitting the report to the AAMC Executive Council, Dr. Coggeshall reported that committee members and consultants had interviewed more than 85 persons during the study. In addition, five regional meetings were held to obtain the views of deans of schools of medicine and other university officials. Dr. Coggeshall wrote also:

". . . surprising unanimity of concern was found among medical educators, university officials, public officials and others about problems in the field of medical education. Few persons interviewed believe improvements needed are matters of minor adjustment. Most point to the need to take major steps to improve medical education—to enable the nation to produce more and better prepared physicians and other health personnel. There is a rather consistent pattern of thought that the quality of education is good but not fully geared to future needs. Most impressive is the repeated assertion that there is need for some organization . . . to assume a more aggressive and correlative role if future needs in the field of education for all health personnel are to be met."

An internationally recognized authority on malaria and other tropical diseases, Dr. Coggeshall has pursued a career as teacher, scientific investigator and administrator. From 1947 until 1960, he was Dean of the Division of the Biological Sciences at the University of Chicago. The school of medicine and the university medical center are included in this division, as are graduate teaching and research in the non-clinical life sciences. Dr. Coggeshall has been

elected to membership in two of the nation's leading scientific organizations, the National Academy of Sciences and the American Philosophical Society. Born May 7, 1901, Dr. Coggeshall earned his B.A. (1922), M.A. (1923) and M.D. (1928) at Indiana University. (News release prepared by the Office of Public Relations, the University of Chicago, for the Association of American Medical Colleges.)

## 19th Clinical Meeting of the American Medical Association

*JAMES Z. APPEL, M.D.*
*President, American Medical Association*

THE AMERICAN physician is well aware that he must keep abreast of new findings in therapy and research to be able to provide the best possible care for his patients.

He must know about new drugs and their uses and possible side-effects. He must know about new techniques of surgery. He must know of the promising leads towards solution of now baffling physical ills. And he must know of the sometimes small but often important new successes in finding better ways to treat the already treatable diseases.

There's no argument about the premise that the physician must keep learning. The problem is how? With the average American physician now working a 58-hour week, and many putting in hours far above the average, how can the physician find the time to study and keep abreast?

One of the most compact methods of checking up on new developments is to attend the annual clinical convention of the American Medical Association. The program of this convention is designed primarily for the man in practice. The speakers will read papers that bring to the man in practice the latest findings of others in his area.

This year the clinical convention will be held in my home state of Pennsylvania, Nov. 28-Dec. 1, in Philadelphia.

The Philadelphia meeting offers an excellent scientific program. Topics of wide interest will be discussed by outstanding teachers. All of the various sessions and workshops will contribute to the continuing education of the practicing physician.

Particularly noteworthy are the postgraduate courses in gynecology and obstetrics and in cardiovascular therapeutics, consisting of two series of comprehensive lectures.

Other sessions will be devoted to timely subjects, followed by question-and-answer or discussion periods. Fireside conferences and breakfast roundtables will provide further time for informal discussion.

It promises to be a stimulating four days, worthy of the busy physician's time. I urge every physician to take advantage of the educational opportunity represented by the clinicial convention.

## Editorial Notes...

**Major medical expense insurance last year protected 47,001,000 Americans and paid out almost a billion dollars, $942,528,000 to be exact.** Major medical had only 108,000 customers in 1951. It is the fastest growing type of medical insurance. It should be. It doesn't cover the first part of an illness which is the easiest part for the patient to pay for all by himself and it makes a partner of the patient on the part it does pay. Both characteristics make major medical companies able to cover very large amounts at an economical price.

**Four frequently used hospital medications. sodium seco-barbital capsules, sodium pentobarbital capsules, sodium amobarbital capsules and phenobarbital sodium injection ampuls have been added to the Merrell DAC System.** DAC stands for Distribution and Control. Under this system, tablets and capsules are packaged in continuous tapes. Each individual dosage form is identified by labeling on the tape and is protected from contamination until time of administration. Ampuls are packaged in transparent plastic boxes. The

system is advantageous, especially for hospitals, since it facilitates inventory and control and enhances the accuracy of administration and dosage.

**The Food and Drug Administration have under study regulations which will limit the use of vitamin D.** The effect of the proposed regulations would be to restrict daily dosage to 400 USP units. This dosage meets the full requirements for infants, children and nursing mothers. While overdosage by vitamin D has not been proved to be harmful, the scientists point out that excessive intake is of no value.

**The AMA has found it necessary to issue warnings to athletes and coaches concerning the unauthorized use of DMSO and androgenic-anabolic steroids.** Previous warnings were directed against the use of amphetamines as "pep pills" for athletes. The case against DMSO is simply that it is still in the testing stage. Not enough is known about it to warrant its use as a prescription drug, let alone its uncontrolled use by medical laymen. Androgenic-anabolic steroids, when used indiscriminately, produce serious hormonal changes at almost any age, including regression of adult sexual organs to the prepubertal state. Besides the detrimental effects, the steroids have never been demonstrated to produce any significant difference in athletic performances.

**The Veterans Administration is granting from 60 to 90-day leaves to its staff physicians who can be spared from their state side duties to enable them to participate in Project Viet-Nam.** Viet Nam has been under war conditions for over 20 years, has 16 million people and about 700 physicians. The AMA and all government agencies are encouraging volunteer physicians to serve on a rotating basis in civilian hospitals. ◄

## Pick Most Competent Detailman

Have you ever wanted to pass along a compliment about a drug company representative? Would you like to let his boss know that he has been especially helpful? Here's your chance. We want to find out the most popular, most helpful detailman in the state of Indiana. We want to recognize his service to medicine and in recognizing him, express appreciation to all these men who, in the proper fulfillment of their duties, are a real service to Indiana medicine. Please drop in an envelope and mail to *The Journal,* ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

I vote for the below named man (men) whom I consider the most helpful drug company representative (s) now calling on me. (Name as many as three)

Name of detailman _____ Company _____

_____ _____

_____ _____

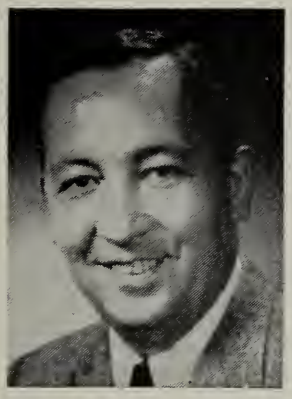
Remarks, if any:

_____

Your name (optional)

# President's Page

As a parting message to my fellow physicians in Indiana, I wish to thank all the active participants in our multifaceted program of the Indiana State Medical Association. I also wish to encourage every physician to become more active, more alert and knowledgeable of the Indiana State Medical Association since it is your image.



Your president accepted this position as a job of basic public relations and information, neither to be a dictator nor a formulator of the program and activity of the association. I have traveled many miles, visited many societies and ancillary groups bringing greetings and best wishes to their programs. It has been a pleasure to represent you and I have always attempted to present the Hoosier physicians in their best light.

During the year my observations have brought forward to me three areas for the physicians and the association where they must work diligently to preserve the freedom of medicine and the status of the physicians as we have enjoyed it in the past:

1. Attention by everyone to the problems of federal and state legislation, their impact and encroachment on the patient-physician relationships.
2. To the problems of communication for our physicians to understand and foresee possible pitfalls and problems. It has been difficult even with the outstanding performance of the Indiana State Medical Association executive staff to inform the physicians of their actions and program.
3. It might be considered communications, but I feel it falls in the avenue of cooperation of the profession with the various ancillary health organizations involved and interested in specific areas of health care. We sometimes neglect to take the time to be important spokes in the wheel of an organization which is trying to promote better health for our citizens. We further need to cooperate with other organizations who are interested in our great state and our great country, trying to understand their problems and trying to promote a better understanding of ours.

Thanks for the opportunity of serving you and working with you.

To your new officers I wish them well. They are dedicated, competent and knowledgeable leaders and I am sure will prove to be outstanding workers for your future. Congratulations to Dr. Neumann and best wishes for a new year.



# The Woman's Auxiliary

## REPORTS TO ISMA

Repeated requests for timely health talks plague the busy physician. The problem of preparing and presenting medical material to a lay group is frustrating. The very real question of misinterpretation of information with ensuing repercussions assumes monumental proportions behind which the M.D. may hide.



This is the spot where an informed, alert and knowledgeable auxiliary may be of assistance. It is easy for women to be inquisitive—they inherit the trait, it's said, because they're women. Through well-placed questions, the real interest of a group may be evaluated and the educational material best suited to their needs made available. With the physician or an advisory board of a medical group approving and guiding the auxiliary, a most satisfactory solution is reached.

Ours is a health-oriented organization and for the purpose of disseminating health material, the Annual Workshop for each of the four regions has been expanded this year. October 13th and 14th, the North Central Region will meet in Chicago and state chairmen of Health Careers, Community Service, Legislation, Mental Health, AMA-ERF and Membership will have the opportunity of receiving material first-hand from national officers and chairmen. The attendance is by invitation only and will be underwritten by national.

The term "doctor" refers to a learned man or teacher who treats disease or physical disorders. Comedians belittle and joke about the "doc" because this is an attention-getter, but, good health is essential to a happy, productive life and it is the physician who seeks to prevent or overcome disease. The community knows its health is dependent on the physical environment which supports the skills and services of many trained people and acknowledges the position of the physician.

Nationwide, the week of November 7th to 13th is established as Community Health Week with a slogan of "Teaming up for Better Health." It's a special time set aside to better acquaint all residents with medical advances and with the wealth of health facilities and services which are available locally.

Ruth V. Demetrone

**LOMOTIL**—*Pharmacologic Activity.*

The significant pharmacologic actions of Lomotil are summarized as follows:

Evidence indicates that Lomotil acts directly by inhibiting excess peristalsis.

Lomotil is not known to inhibit nonpropulsive intestinal movements.

Roentgenograms demonstrate that this activity occurs within two hours after oral administration and persists for at least six hours.

Studies in the rat show Lomotil to be more effective in inhibiting fecal excretion than either codeine or morphine.

Analgesic, anticholinergic, mydriatic and gastric secretory effects have not been significant.

Reduction of propulsive motility with Lomotil relieves spasm and cramping, allows physiologic absorption of fluid and reduces frequency of evacuations to provide prompt, symptomatic control of virtually all diarrheas.

# LOMOTIL® tablets liquid

Each tablet and each 5 cc. of liquid contains:

diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)

atropine sulfate ..... 0.025 mg.

## slows propulsion · relieves distress · stops diarrhea



*Precautions:* Lomotil is an exempt narcotic preparation of very low addictive potential: more than three million prescriptions have now been written for Lomotil. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

*Side Effects:* Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

*Dosage:* For full therapeutic effect – Rx full therapeutic dosage. The recommended initial daily dosages, *given in divided doses*, until diarrhea is controlled, are:

**Children:**
3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

**Adults:** 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily) **Based on 4 cc. per teaspoonful.*

Maintenance dosage may be as low as one fourth the therapeutic dose.

Lomotil is a brand of diphenoxylate hydrochloride with atropine sulfate; the subtherapeutic amount of atropine is added to discourage deliberate overdosage.

SEARLE *Research in the Service of Medicine*

# Operation Airlift

FT. RILEY, Kansas, was the summer home of the members of the Army Reserve Hospital this year, approximately 300 of which were able to attend.

Each year the reserve officers, nurses and enlisted men and women from the Indianapolis area pack up their hospital and "airlift" it to an Army post somewhere in the United States for two weeks of intensive training.

The hospital force, under the command of Dr. Harry G. Becker, Indianapolis general surgeon, trained at the Irwin U.S. Army Hospital at Ft. Riley this year. During the first week of training, physicians and nurses of the 337th General Hospital (USAR) saw patients while paramedical personnel worked in the laboratory, pharmacy, x-ray, physical therapy departments, motor pool and supply.

The staff includes personnel of a complete unit — including cooks and "dishwashers." The list includes general surgeons, oral surgeons, orthopedic surgeons, internists, roentgenologists, anesthesiologists, psychiatrists, psychologists, social service workers, occupational therapists, dentists, optometrists, nurses, pharmacists, physical therapists and general practitioners.

Dr. Becker, a colonel and commanding officer of the hospital, said that two giant transports and several other commercial airline flights took the majority of the personnel and equipment while 25% of the hospital staff traveled by private conveyance.

The hospital trained in the field during their second week of active duty. They operated a field hospital and processed simulated patients under combat conditions. This rounded out their training and by the end of the active duty period, each member experienced practicing their technics in a garrison-type hospital on an Army post and in addition in a simulated combat area.

The hospital was especially honored this year in being designated by the Department of the Army to receive the Lineage and



**AIRLINE PILOT** welcomes aboard Col. Harry G. Becker, commanding officer of the 337th General Hospital (USAR) as the group leaves for summer training at Ft. Riley, Kansas.



OFFICERS of the 337th board one of the five flights which "airlifted" the personnel and equipment of the hospital to Kansas for intensive training.

Honors of the 90th General Hospital, a World War II, 1,000-bed organization now inactivated. The command accepted with pride the heritage of that fine hospital which was demonstrated during its service in the European Theater of Operations.

In flying the hospital's streamers with the unit's organization flag and in wearing the Meritorious Unit Emblem on their uniforms, the 337th honors the men and women who won them in actual service during that war.

The 337th will take another trip next summer probably during the month of June to a site as yet unselected. Probable destinations under consideration are the Brook Army Medical Center, Ft. Sam Houston, Texas; the Fitzsimmons General Hospital in Denver, Colorado and possibly even Camp McCoy, Wisconsin. ◄



LINEAGE and honors ceremony which presented the 337th with the streamers of the 90th General Hospital, now inactivated. M/Sgt. Eugene Goben is shown presenting the unit colors to the commanding officer.

# Competitive Sports for School-Aged Children*

EDWARD A. TYLER, M.D.†
Indianapolis

IT'S NOT how you play the game, it's whether you win or lose. Did I say that backwards? Actually I feel this is *the* question which must be answered in evaluating our present day competitive sports programs for school-aged children. The safeguards to insure winning may be completely incompatible with losing, and we find ourselves in an either-or situation.

Rather than state my conclusions at the end of this discussion, as if they were arrived at objectively, I will express my biases and then proceed to defend them. I *laud competitive sports for children* as an essential part of their physical and emotional maturing process. I *condemn much of the current* competitive sports program as being damaging to both the physical and emotional maturity of children.

Children become adults. Since most modern adults are either participants or spectators of some competitive sports, let's examine these "matured" products. At any given competitive sports event, spectators far outnumber players—so let's focus on them first. It is my impression that spectators show relatively little interest in admiring the physical skill and coordination of a good athlete; in observing the outstanding, exceptional, or unusual plays; or in watching a closely contested, relatively errorless athletic event. Rather they seem primarily eager to make an irresponsible angry identification with an individual player, a team or the institution these represent, and then demand a smashing, jaw breaking defeat of the opposition even if this has to be achieved by gross violations of the rules and poor officiating. One could hardly consider this to be mature but neither is it foreign to the attitudes we begin to acquire through our school-aged contacts with competitive sports. The adult coaches and spectators, as well as the children, place far more emphasis on winning than on skillful play and much less on a "sportsman-like attitude."

### A Rigid Robot

Well, at least we must give a great deal of credit for the job competitive sports do in assisting good physical development and health — or can we? Competitive sports programs as they currently exist tend to encourage the already physically well-developed child to push himself to the point of exhaustion, to unwisely accept repeated chronic injuries, to pursue one-sided development rather than the acquisition of other physical skills and to become a compulsively rigid robot as he acquires more and more skill in his major athletic pursuit.

The child who is not developing well physically (and is most in need of coaching assistance) is actually discouraged by the coach and his teammates from continuing in any competitive sporting activities. This seems "logical" since the intent in competition is to win, but the problem is how often must one win and against whom. I doubt that our current programs add anything to the physical development of *most* of our children.

Let's digress for a moment and distinguish between the competitive activities in which children *spontaneously* engage as compared to their participation in competitive sports *programs*. In spontaneous activities, a child can withdraw, at least temporarily, when he feels he has reached his limit. He does not have to risk excessive stress or repeated mild but cumulative chronic injuries.

In organized competitive programs this is almost impossible, because temporary

Continued

* Presented at the ISMA Annual Convention, Murat Temple, Oct. 14, 1964.

† Professor of Psychiatry and Director of Undergraduate Education, Department of Psychiatry, I. U. Medical Center.

# Should it make any difference to her that the "500 Viso" won every major design award this last year?

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transient withdrawal as a protective mechanism is unacceptable. The child must "tough it out" or permanently quit, unless he has the excuse of an easily recognized physical incapacity such as a broken leg. (After playing three-quarters of a hard college football game, I used to feel a teammate taken out with a fracture was lucky!)

In most of our current competitive sports programs, the child cannot defend himself against chronic traumata to ankles, knees, hips, cervical spine, shoulders, skulls and teeth which frequently manifest themselves 20 or 30 years later as physical incapacities, painful joints, premature aging, etc.

### A One-Sided "Square"

I introduced the term "one-sidedness" earlier as becoming so preoccupied with the development of one skill that one neglects the development of others. This relates to the emotional as well as the physical maturity of the child. A lucky child may be in a program not harmful to him physically and one that even teaches a healthy respect for the rules, skill, and "sportsman-like attitude."

But the amount of practice involved to maintain a level of performance high enough to be retained in the program is frequently such that it excludes the child from many, if not all, other activities. This interferes with development of his social-skills, his interests in cultural and intellectual pursuits and even his participation in other sports. His sporting activities no longer provide fun when they become his job. Because of the political overtones in international amateur sports and the exploitation of sports for profit by promotors and advertisers, it seems unlikely that this focus on specializing and the resultant one-sidedness will diminish in the foreseeable future.

There are individuals who become extremely skilled in nutrition and devote most of their interest and energies to this choice. They become one-sided, but have chosen a career. On the other hand most, if not all, of us eat, but very few of us become nutritionists or food faddists. Preparing foods and eating is just one of the many enjoyable activities in which we participate frequently and freely.

I could give many such analogies, but my purpose is to raise the point of whether we can have programs for both the one-sided expert-specialists who will make careers of competitive sports and for those who wish to be just everyday garden variety duffers having fun with competitive sports. The latter provides the school-aged child with his necessary ration of physical exercise "nourishment."

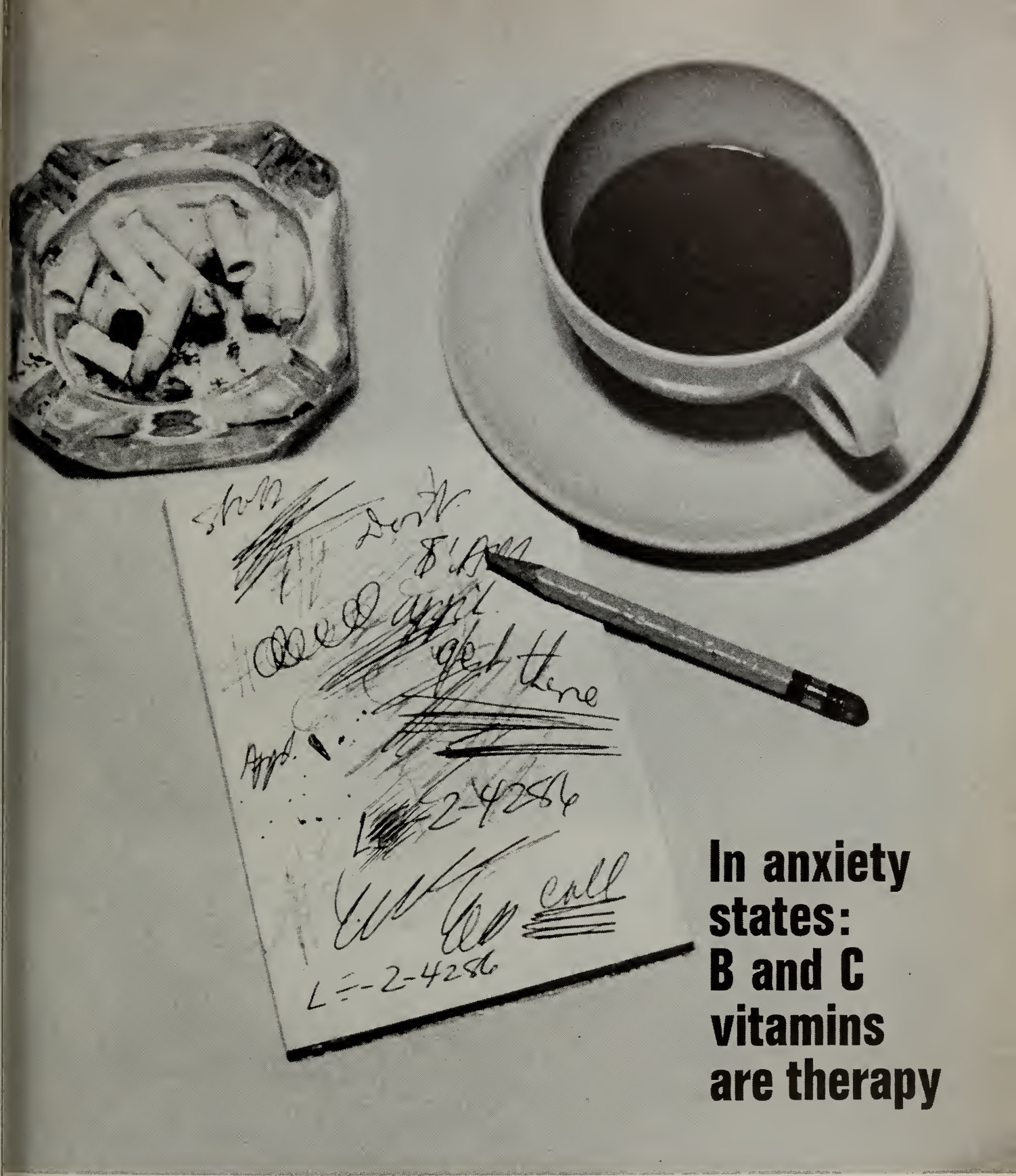
I believe when contestants are evenly matched by selection or handicaps, competitive sports can be invaluable and pleasurable for children or adults who are essentially duffers, Sunday golfers, etc., and never intend to become outstandingly skillful and one-sided. The contestants can appropriately compare themselves with each other rather than with the world's champion.

### Games vs. Contests

Let's again digress and consider why man engages in competitive sports. As a biological creature, man has some very primitive feelings, some of which are rather aggressive and hostile. In order not to need to be constantly on guard against turning his back on his neighbor, he sets up rules for permissible aggressive activities and calls these games, as distinguished from "no holds barred" contests. He plans the competitive game so that once a winner is apparent, within the rules, the contest has limits which allow the loser to come back later for another chance.

Only in the "game of war" must one win at all costs and try to fix one's opponent so that he cannot return for another contest. When man has no outlet but war, he then expresses his more primitive emotional impulses through destructive activities such as riots, gang fights, assaults, (i.e., small personal wars). These are *not* games because there are no mutually agreed upon rules. Man's primitive impulses should not need expression by this uncontrolled behavior in a healthy civilized society. Man has, then, devised his competitive sports with their very clearly specified rules, to allow him to express himself physically and aggressively

Continued




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without total destruction to the loser.

In our present enthusiasm to win, we frequently forget that the true skill of a competitive athlete is to win *without* stepping out of bounds. When he wins by violating the rules, even accidentally, he really hasn't won the game at all. He has changed the rules and consequently made up a new game. He is playing one game and his opponent is playing another. Even if both opponents accidentally or intentionally violate the rules, they are now playing a game in which the rules are rather vague and poorly understood. There is no longer any contest of skills.

When we forget to teach children that a sport is really a contest of skills, not manipulations, we are no longer teaching them the sense of responsibility for learning, understanding and carrying out mutually agreed upon rules which are essential to their becoming physically and emotionally mature adults. The attitudes a child develops toward law, authority and respect for the rights of others will not appreciably differ from those he learns towards the rules of competitive games. His adult attitudes are nothing more than a sophisticated and somewhat more enlightened version what he has learned as a child.

In summary, I believe competitive games are essential to the physical and emotional maturity of children whom we expect to become healthy adults. But children must learn and adults must remember that games have rules which must be mutually understood, acceptable and followed. Most children need the type of self-protection from over-extending themselves that is usually found in spontaneous competitive activities but rarely found in today's organized competitive sports programs.

Children can also be physically and emotionally hurt by participation in or rejection from competitive sports programs. Their adult boosters and coaches must decide and then give more than "lip-service" to where they stand on my first question. Is it how you play the game or whether you win or lose that really counts?

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Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

**Contraindications**
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

**Precautions**
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

**Warning**
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

**Adverse Reactions**
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

**Average Dosage**
Initially, give 400 mg. daily (one tablet or capsule q.i.d.), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. To minimize gastric distress, Butazolidin alka capsules may be the preferred form.

**Note:** The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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| Butazolidin, brand of phenylbutazone | 100 mg. |
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# Medical Care of Compensation Cases in Indiana

PHILIP T. HOLLAND, M.D.
Bloomington

IN presenting the basic mechanisms for treating cases under the compensation laws of Indiana, a simile may be drawn with the game of basketball. There are five players and the ball (the acts or action) which at times may be passed from any one to any other of the players.

The rule book is the law of the state of Indiana as related to the care of compensable accidents and illnesses. The referees and the umpires to settle disputed points are the members of the state Industrial Board. As in basketball, there are a few players on the bench in addition to the first-line starters. These may be substituted at times under various circumstances to carry out some special play.

In Figure 1 are indicated the normal relationships between the various players as well as the functions of the substitutes and the players for whom they substitute.

The following tabulation outlines the common interplays that we *see*, or *should* see, between the various principal players; namely the employer, the employee, the insurance company adjuster and the doctor.

The activities and uses of the substitute players appear in the remarks relating to the job each one of the first-line starters has in any given situation in which we assume everything works ideally.

### The Employer

1. He wants to have his obligations under the law taken care of without any more complications than are necessary.
2. He should try to conduct and maintain safe, healthy, working conditions.
3. If injury or illness does occur, he wants his employees effectively cared for.
4. His insurance coverage is with the insurance company—but the adjuster is the man with whom he will have the most contact.
5. He must see that prompt notification of injury or illness is conveyed to the adjuster.
6. He must see that employees are sent promptly for medical attention.
7. He must authenticate to the medical attendant the industrial nature of the condition.
8. He should cooperate with the insurance company, the medical attendant and the employee in regard to rehabilitating the employee and getting him back on full-time duty. If he does this, it is often possible to get a man back to full usefulness more rapidly, which will lessen the compensation payments for time off and lower his compensation premiums.
9. He should realize that the physician can serve as a source of information which can be helpful to him through his contacts with chemists, consultants, facilities such as the State Board of Health and other sources of useful information.

### The Employee

1. Naturally, he wants to avoid illness and injury.
2. When either occurs in the course of or as a result of his employment, he should expect proper, efficient care.
3. He owes an obligation to his employer, to himself, the company and the doctor to cooperate faithfully in the treatment prescribed.
4. He owes an obligation to use every effort to assist in his progress and rehabilitation and to return to his employment as soon as it is safe and proper.
5. He should expect that every effort will be made to return him to good health and work with as little impairment as possible.
6. He should not expect the impossible.

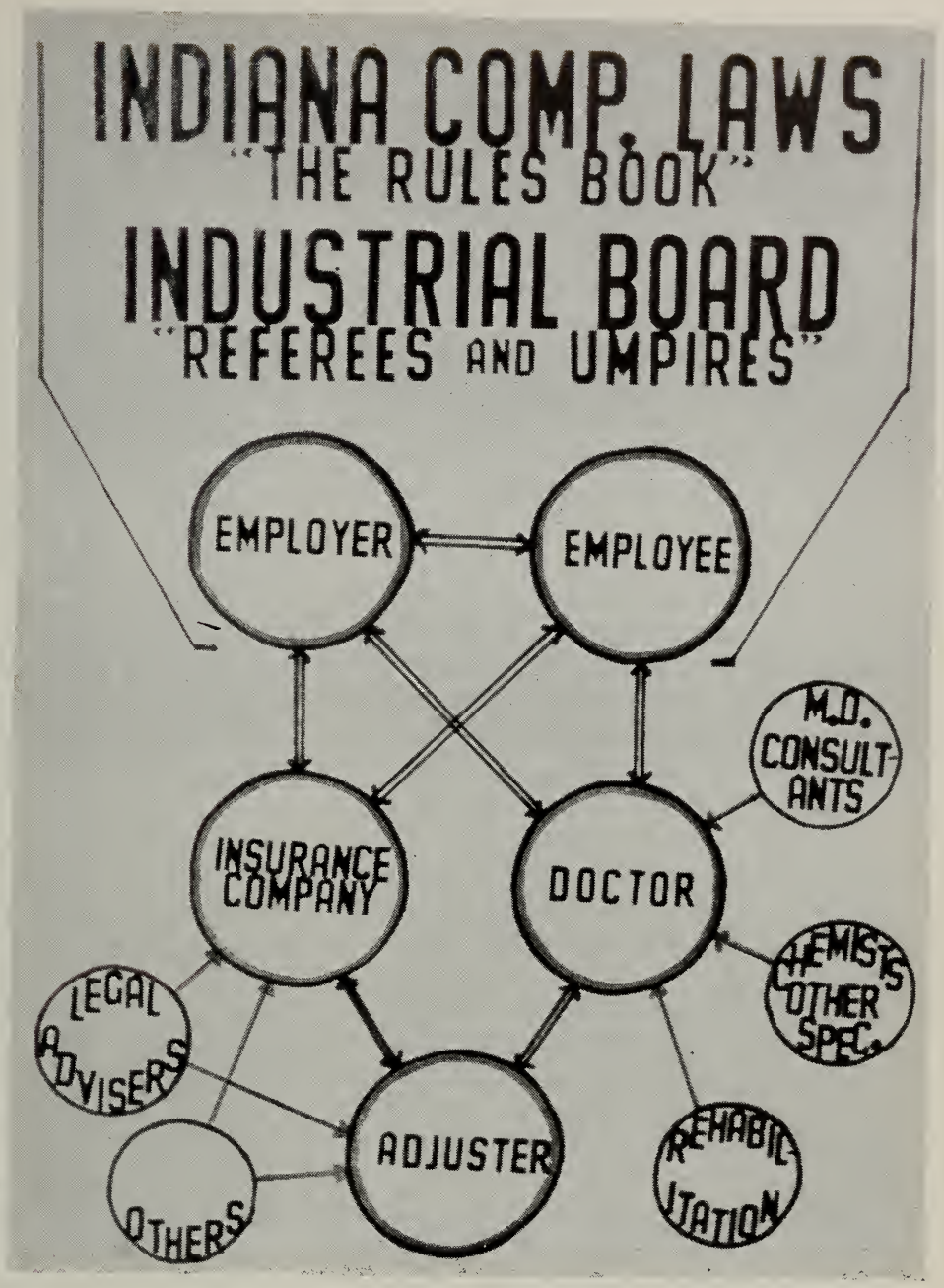



FIGURE 1

7. He should expect the employer and the company to comply with the law without his having to exert undue pressure.
8. He should expect and receive fair treatment in his relations with the employer, adjuster, company and physician.

**The Insurance Company Officials**

1. They should expect prompt and accurate action on the part of the employer, employee, doctor and adjuster.
2. They should respect the doctor's reputation and ability and should expect from him his best and sincere efforts on behalf of their patients.
3. They should expect normal fees for services rendered and should not be expected to pay exorbitant fees that are out of line with customary charges in the community involved, for comparable work by men of like ability.
4. They should expect protection against malingering or falsification if and when the physician encounters such.
5. They should expect constructive cooperation between the adjuster and the physician to see that things are done correctly and on time.
6. They should pay their bills and settlements promptly and should likewise be paid their premiums or other obligations promptly.

### The Adjuster

1. He represents his company to all persons involved and his actions are considered in that light.
2. He should keep currently informed on the cases with which he is charged.
3. He should be guided by the doctor's advice as to the patient's progress, time of total disability, partial disability and permanent impairments and has a right to expect careful and considered advice on these matters from the physician.
4. He needs to realize that he cannot hasten the healing of patients by a desire to close out a file by some specific date.
5. He should not tie the physician's hands, but should realize that the physician's judgment is the guide to special examinations, consultations, the use of special facilities, or if exceptions to general rules are indicated.
6. He should utilize his physician as a source of information in many fields, not only through information from the doctor himself, but that which he can procure from other sources as indicated in Figure 1.
7. He should expect and receive proper reports from the doctor to allow him to send the compensation checks due and to set up reserves where permanent partial impairment is anticipated. He should bear in mind, however, that a doctor's office nowadays is heavily loaded with paper work, and the number of reports and details requested should be within reason.
8. He should realize that the physician sees the patient many times and can often advise as to *early* settlement of a case, *delaying* settlement or concerning points of value concerning prognosis.
9. He should expect information from the physician if there is any suspicion of malingering or misrepresentation and should immediately begin investigating the facts of any case so suspicioned.
10. He is expected to settle cases, to the best of his ability, in compliance with the law and as a representative of his company. If the patient is in good faith, he should be dealt with similarly.
11. He should expect a realistic impairment rating from the doctor to guide in settlement. If the doctor gives him an unrealistically low estimate, the patient will not be satisfied and settlement cannot be accomplished. Litigation may also be encouraged at greater expense to the company than would have been the case if settlement had been accomplished without litigation, attorney's fees, court expenses, etc. If he feels ratings are unrealistically high, he should confer with the doctor and if no agreement can be reached, they should then consult another doctor for an additional rating estimate.
12. He must realize that a doctor's first obligation at all times is the recovery of his patient, but that most doctors will be fair in their attempts to see that unfairness to the company is *not allowed either*. Most doctors are fairly alert at discerning malingering, especially if they have been taking care of compensation cases for some time! If the adjuster has evidence or information to this effect, he should let the *doctor* know it immediately to alert *him!*

### The Doctor

1. He must realize the adjuster is, like himself, a human being and has a job to do that is frequently neither simple nor easy.
2. He must realize that the adjuster is in the position of authorizing payment for his services, the patient's unemployment checks, consultations, medicine, hospitalization and any other items of expense. He is entitled to know for what he is paying, as he is accountable to his company for justification of expenditures. The adjuster also has to set aside for his company a reserve for payment of permanent partial impairment settlements. If he can anticipate some approximate impairment values, he serves the doctor, the patient and his company better.
3. The information the doctor has to give the insurance company concerning the patient is necessary, *but is not* to be passed on to *other persons* any more than one would discuss *one patient's ail-*

*ments* with *other patients.*

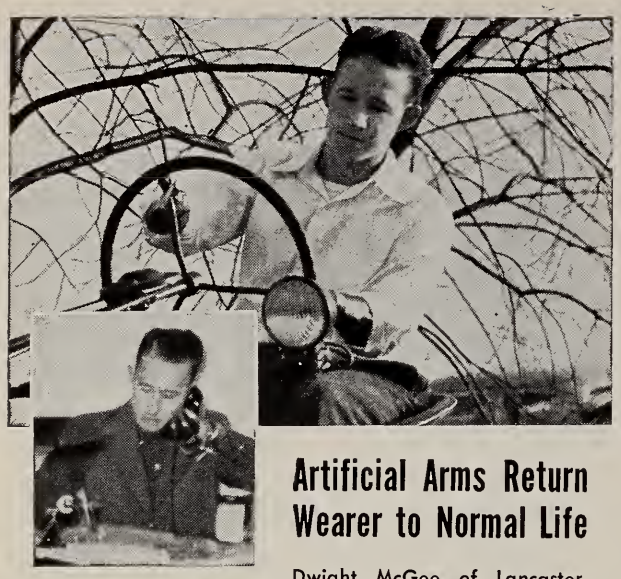
4. The adjuster has to make the settlements. The doctor is neither an adjuster nor an attorney. Therefore, he should give an accurate description of the nature and extent of injury and of the patient's condition. Impairment ratings must be detailed, descriptive and objective. The doctor should be aware of the compensation law indemnity schedule for the state so that he realizes what his percentages mean in settlements. He should not foment litigation by ridiculously low percentages nor penalize the company unfairly by unduly high "sympathy" ratings. He should understand the law and be objective. It is no favor to the company to subject them to a lawsuit or hearing which would not have been necessary if a realistic rating had been given. The doctor must not yield to any pressure from any direction in making ratings.
5. He must make the patient understand that it is to the doctor's credit if he achieves a good result and that if he does, he sincerely serves the patient, the insurance company and his own reputation. The patient should understand that the better the results, the less the company is out for impairment settlement. Therefore, the company *and* the doctor are sincerely interested in his welfare and recovery. If this viewpoint is presented to patients, they will agree and cooperate better. They then realize that the company does not want a cheap or ineffective doctor, because what they "save" in *fees* may cost them much more in *settlements.*
6. If a doctor's care and impairment ratings are both as they should be, he will not have to appear at very many hearings; only ones in which there is a genuine divergence of honest opinion or an unreasonable and extortionate patient or attorney.
7. The doctor should realize that the compensation laws are, as a general rule, not very well understood by many attorneys who are otherwise good in their field. He must keep himself adequately informed to avoid "muddying the water" so the adjuster can effect a proper and orderly settlement according to law.
8. Most adjusters deal fairly in their settlements, but the physician, in the same way the adjuster protects the company from imposition, should see that his patient is treated fairly also. He can do this quite properly by adequate and accurate statements which will be in keeping with his obligation as a physician.
9. He should realize that he owes a real obligation to the adjusters whose cases he handles and to the companies whose employees he cares for, to see that they receive proper attention.
10. He should encourage the use of his knowledge and sources of information to help eliminate procedures and situations which cause accidents or illness and so help employers, the company and employees. This he should regard as part of his job.
11. When the doctor does have to appear at a hearing, he should have his records in good order; should anticipate proper and direct questions; should be prepared to give honest answers and opinions based on the facts and his *adequate* medical knowledge and be prepared to defend the same against adverse questioning. It *is* permissible *not* to know everything in *every* field of medicine and there need be no cause for shame, confusion or embarrassment. Proper review and preparation *before* testifying will prevent most of the unpleasantness of testifying.
12. The fact that an insurance company is paying the bills is no excuse for exorbitant charges. It should be, in fact, the primary reason for keeping them reasonable. There is much more assurance of their payment if they are in line with other physician's fees.
13. The doctor is entitled to prompt and definite notification from the employer and/or the company that a given situation is definitely considered a compensation situation. It is quite irritating to be "stuck" with extensive care of a patient and then to find the patient and

employer both disavow responsibility. The doctor should expect to be asked, occasionally, if a given situation is, or is not, employment related. Even if he discovers it is not, he should be paid for the necessary investigation required to answer the question.

14. From all of the above, it should be apparent that the doctor must realize that *good* records and at least the necessary amount of reporting are *absolutely essential* if he is to handle industrial compensation cases.

15. The care of compensation injuries can be satisfying, interesting and worthwhile. It is possible to serve one's patients conscientiously and feel satisfaction at achieving good results. There are problems, as in any field, but complete information and experience makes them manageable. ◄

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# Annual Meeting Dates of Professional Medical and Allied Organizations

**AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION**
**Date** Nov. 28—Dec. 1, 1965
**Place** Philadelphia, Pa.

**INDIANA ACADEMY OF GENERAL PRACTICE**
**Date** May 3-5, 1966
**Place** Fort Wayne

**INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**
**Date** May 4-5, 1966
**Place** French Lick Sheraton Hotel, French Lick

**INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS**
**Date** December 2, 3 and 4
**Place** Elkhart

**INDIANA HOSPITAL ASSOCIATION**
**Date** October 27-29, 1965
**Place** French Lick

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
**Date** October 10-13, 1966.
**Place** French Lick, Indiana

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
**Date** Second Wednesday of every month, October through May
**Place** The Athenaeum, Indianapolis

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
**Date** Nov. 10, 1965
**Place** Marott Hotel, Indianapolis

**INDIANA SOCIETY OF INTERNAL MEDICINE**
**Date** Sept. 25-26, 1965
**Place** South Bend

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
**Date** Fourth Wednesday of every month, September through June
**Place** For location and program, inquire Beatty Memorial Hospital, Westville





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*Medical Panorama*

# "Think on These Things"

## Suggestions re: DeBakey Commission Report

A. W. CAVINS, M.D.
Terre Haute

In the July issue of the *Journal of the Florida Medical Association* is an editorial concerned with S.B. 596 and H.B. 3140 which shows considerable thought on the part of its author* and offers food for more thought to the rest of us.

To preserve the proper context, it is necessary to quote at length, but we believe that this is worthwhile material:

> Senate Bill 596 and House Bill 3140 have been introduced in the Congress of the United States to implement the President's Commission on Heart Disease, Cancer and Stroke (DeBakey Commission Report). Each involves the physician, the medical school and the hospital. The complete bills comprise many pages. Those portions of most importance to members of the Florida Medical Association are:
>
> 1. A network of regional medical complexes now limited to the fight against heart disease, cancer, stroke, and other major diseases is to be associated with a medical school having a teaching hospital as its core, with satellite installations in nearby community hospitals serving as clinical research centers and specialized diagnostic treatment centers.
>
> 2. Fifty million dollars is authorized in fiscal 1966 and such amounts as may be necessary for each of the four next fiscal years to establish and operate this system. These funds would cover the entire cost of planning a complex and up to 90% of the cost for installation of and equipment for each complex. Salaries of technicians and specialists who would be involved in the program will be met by government grant. Operational cost will be the responsibility of the medical center or the satellite community hospital.
>
> 3. Provisional control will be vested in medical school selected specialists who would direct and control the community hospital stations and instruct the community physician in newer techniques, teaching as they directed patient care.
>
> 4. Operational cost of the stations may be billed to the patient after negotiations with some government agency as to the proper scale of billing.
>
> 5. The Secretary of Health, Education, and Welfare will appoint an Advisory Council of 13 men to be chaired by the Surgeon General of the Public Health Service to build these complexes and guide their operation.
>
> * * * *
>
> This plan envisions 550 treatment stations, each associated with a teaching hospital center. Staffing of these stations on a professional level alone will at present be impossible, as there is no such source of well trained specialists equipped to assume such responsibility. With present training programs this manpower need cannot be met in the foreseeable future.
>
> Each community hospital within the state of Florida having an accredited intern and residency training program has at present a well trained devoted group of specialists voluntarily giving their time for house staff training and improved patient care. This group will be bypassed as the program is now planned, and each of us must wonder just what our reaction will be when our voluntary efforts are assumed by a government-subsidized replacement. This group of physicians who are now always present for any teaching or patient care responsibility will naturally lose interest and fade away. In each community there are two groups of people —the one giving, hopefully to improve; the other satisfied within themselves and consequently giving little. The first group will be discouraged, and the second will not be helped, for one must recognize the need for help before help can be given. A subsidized replacement can only produce a decreasing interest in the giving group.
>
> Our medical schools through participation will become tremendous complexes with each disciple at each satellite station spreading the gospel by implication and word that his alma mater is the only place

* The Editor of *The Journal* of the F.M.A. is Thad Moseley, M.D.

for good medical care, and that the so-called LMD (local medical doctor) is not quite up to the standard of the medical center and is passé. Indeed, he may well become so with such odds against him.

By this plan the government is projected into the personal care of all patients, for the bill as written states: AND OTHER MAJOR DISEASES . . . SUCH FUNDS AS MAY BE NECESSARY. These open end statements are much broader than the present so-called Medicare bill, for they apply to all people and for all things medical.

* * * *

A positive plan is needed to guide our legislators in voting out a bill, if some such legislation is inevitable, which will utilize proposed funds at a local level to (a) improve communications between the community hospital professional staff and our medical school staff by exchange of residents and teaching personnel; (b) employ full time specialty educators for house staff training, knowing that through this training there will be improved patient care; (c) offer our resident training groups at each level a centrally prepared examination each year to determine the effectiveness of each residency program and to allow the director of each program to know his strength and his weaknesses; (d) encourage the exchange of service teaching personnel between community hospitals, as such visits would allow each to learn from the other and hopefully bring new ideas to the host institution; (e) improve the image of our contributing local medical doctor in the eyes of the nearby teaching institutions and his community by stressing his abilities and achievements rather than to damage this physician by implication.

These suggestions will constitute a start toward a positive approach that will go far to obviate the criticisms of medical care for the average person as advanced by the DeBakey Commission.

* * * *

Think on these things. If we truthfully say we can and will fulfill this responsibility, we should at once arrange a meeting with representatives of our medical schools, State Board of Health, Florida Medical Association, Florida Hospital Association, specialty leaders and our community hospital professional service directors to formulate a positive approach—one we can pridefully cooperate with and which will in the end provide the best possible patient care.

The advice of Paul of Tarsus is still good . . . "if there be any virtue, and if there be any praise, think on these things."

And it may take a lot of thinking, too. ◄

## How It Affects You

Speaking of spending, you'll work for the government six days more this year. Last year you worked an average of 111 days to pay your total tax bill. This year, due to increased spending and national debt, you'll toil 117 days before you have met your obligation.

Of course, this will deprive your family of that much spending power and retard your standard of living. At the same time, runaway inflation caused by big government spending will dilute the buying strength of what you have left.

President Johnson has proposed a new agency to help taxpayers plan their budgets. I think the American wage earner could teach our budget busters some economy lessons.—From "Inside Washington," by Congressman Earl Wilson.

*Medicine At Law*

# DECISIONS AND OPINIONS

**Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.**

*Improper Comment on Physician's Testimony*—In a suit by a driver for damages for injuries suffered in a collision with a truck owned by the city, a trial court erred in permitting a remark by the attorney for the city suggesting that the testimony of a physician could never be questioned, the Pennsylvania Supreme Court ruled.

The driver's attorney called as a witness another attorney employed by him, who testified as to what he had observed at an examination of the driver by a physician for the city. The attorney for the city then called the driver's attorney as a witness and, on cross-examination, asked him numerous questions having no bearing on the case. He also asked the driver's attorney whether he knew of any other case where an attorney sent someone else to observe a physical examination with the observer later testifying "against the word of the examining physician." The phrase, "against the word of the examining physician" suggested to the jury that a physician's testimony can never be questioned, the court said. It is fundamental that the testimony of any witness, regardless of his profession or calling, may be questioned in a trial court.

*Marcus v. City of Pittsburgh,* 203 A.2d 317 (Pa., Sept. 15, 1964).

*Jury's Punitive Damage Award Against Manufacturer of MER/29 Reduced*—A jury's award of $500,000 punitive damages in a suit against the manufacturer of MER/29 by a patient who developed cataracts, suffered loss of hair and whose skin became scaly after using the drug was reduced to $250,000 by a California trial court on the ground that the evidence was insufficient to justify damages of the size awarded. The jury's award of $175,000 actual damages was left intact.

In moving for a new trial on the ground that the punitive damages were excessive, the manufacturer had contended that a pattern of $500,000 damage awards in MER/29 cases throughout the country would destroy it. It is expected that the manufacturer will appeal on the ground that the punitive damage award, even as reduced, is excessive. (News Release, San Francisco, Cal., June 28, 1965.)

*Judgment Against Hospital in Suit for Patient's Fall Reversed*—In a suit for damages against a hospital for the death of a patient as the result of injuries sustained when she fell while left unattended, a trial court erred in submitting two of the three charges of the hospital's alleged negligence to the jury, the Supreme Court of Errors of Connecticut ruled. The judgment against the hospital was reversed and the case remanded for a new trial.

A nurse placed the patient on a bedpan on a straight chair near the bed. She then left the room to take the temperatures of other patients, saying that she would return in a few minutes. During her absence, the patient fainted and fell to the floor, sustaining the injuries which caused her death.

It was alleged that the hospital was negligent in that it failed to: (1) adequately staff the hospital, (2) provide proper facilities and equipment, and (3) adopt and enforce proper regulations. The trial court submitted all three charges of the hospital's negligence to the jury. The jury's verdict against the hospital was a general one. Therefore, the basis for its decision was not known.

The only evidence offered on the issue of

the hospital's failure to provide adequate equipment was that describing the chair and bedpan used by the nurse. That evidence did no more than indicate that the nurse may have been negligent and the hospital would not be liable for her negligence. Therefore, this issue should not have been submitted to the jury, the court said. Nor should the issue of the hospital's negligence in failing to adopt and enforce proper regulations have been submitted to the jury. The only evidence remotely bearing on the issue was that relating to the nurse's duty to take temperatures. Since the verdict was general, and two of the specified omissions on which the claim that the hospital was negligent was based should not have been submitted to the jury, the judgment against the hospital could not stand, the court said.

*Shay v. St. Raphael Hospital,* 210 A. 2d 664 (Conn., May 25, 1965).

*New Trial Ordered in Suit Against Hospital for Loss of Eye*—In a suit by a patient against a hospital for damages for the loss of his eye as the result of postoperative infection, a trial court erred in directing a verdict for the hospital, the Kansas Supreme Court ruled. There was evidence from which the jury could have found that the hospital was negligent and that its negligence was the proximate cause of the loss of the eye.

About noon of the day after a cataract was removed from his left eye, the patient began to suffer extreme pain in the eye. He asked the nurse to call his physician and, when she said he was out of town, he asked her to call an intern or some other physician. The nurse said she could not do so without his physician's consent. When his physician examined his eye the following afternoon, it was infected and subsequently had to be removed.

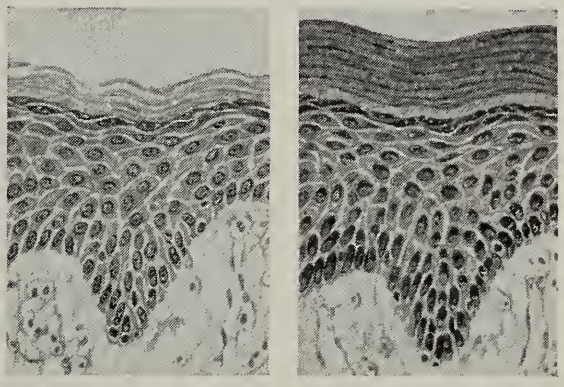
A physician testified that, in his opinion, the nurse's failure to call another physician for the patient when he asked her to do so was not in accordance with the approved procedures of hospitals in the community. The patient's physician testified that the infection could have been caused by any one of the three instruments which entered the

Continued





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**References:** (1) Becker, Jr., S. W.: J.A.M.A. 173: 1483-1485, 1960; (2) Pathak, M. A., and Fitzpatrick, T. B.: J. Investig. Dermat. 32:509-518, 1959; (3) Pathak, M. A., Fellman, J. H., and Kaufman, K. D.: 33:165-183, 1960.

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Continued

eye during the operation. The instruments were sterilized by the hospital. The infection was discovered a little more than 48 hours after the operation. The patient's physician testified that the incubation period for bacteria was 48 hours to five days. This evidence was sufficient to raise a question for the jury as to the hospital's liability, the court said. The case was remanded for a new trial.

*Yeates v. Harms,* 401 P.2d 659 (Kan., May 4, 1965).

*Damages Recovered from Physician who Signed Commitment Papers*—A jury awarded damages of $1,000 in a suit against a physician by a woman who was confined for one night on the strength of emergency commitment papers signed by the physician. The woman was released the next day after a sanity hearing. The $1,000, which was the amount the woman had sought, was for the fees of an attorney and a medical expert and for time lost from work as the result of the confinement.

*Luckenbill v. Allison,* Cir. Ct., DuPage Co., Docket No. 3-62-1022 (Ill., April 30, 1965). ◄




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*(One of a series prepared by Blue Cross-Blue Shield)*

The percentage of "returns" is the key to the comparative value of health care plans. A valid judgment of a program's worth can be made by determining how much of what is collected from members or policy holders is "returned" to them in the form of hospital and medical care benefits.

Indiana Blue Cross-Blue Shield in 1964 (group and direct pay combined) returned 93 cents of each membership fee dollar received for members' hospital and doctor bills. The 19 leading private insurance companies returned an average of 81 cents on the dollar. Thus we returned an average of 12 cents on the dollar more than our leading competitors.

Our comparative performance was even better for individual (direct pay) members. In 1964 we paid out 95 cents of each dollar received from direct pay members for hospital and doctor bills. The 24 leading commercial companies active in this field returned an average of 64.7 cents on the dollar. Our direct pay members received in benefits 30.3 cents more of each dollar paid in than was received by those individuals with commercial coverage.

This comparison comes from data in *Argus Chart, 1965, Accident and Sickness,* a standard reference publication giving the operational data of the insurance industry. It proves again that year after year we do a better job for our members than private companies. That's true for both group and individual members.

Our payout not only was better in terms of the average, but better than any one company in the group and individual combined field, or individual alone. We paid out 93 cents on the dollar in the group and individual combined field, and our nearest competitor paid out 89 cents on the dollar.

Indiana Blue Cross-Blue Shield paid out 95 cents of each dollar received from direct pay members. Our nearest competitor paid out 93.6. But the next highest was only 80 cents on the dollar, and the three largest private companies paid out 69.2, 67.2 and 61.2. For example, the leading private company reported premiums earned totaling $171,122,732, and claims incurred in the amount of $115,036,031. This type of performance is reported year after year and millions upon millions of dollars paid in for health care are never paid out for health care.

Blue Cross-Blue Shield believes that money paid in for health care should be paid out for health care and operates on that basis. Year after year our percentage of return is high because such a return is part of our basic philosophy. We believe community service operation is the best solution to the problem of financing health care and the proof is in our performance. ◄

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Public Relations Division


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John C. Linson, 1761 Blue Licks Road, Lexington, Ky.

### SPECIALISTS

John G. Ziegler, 17701 S. W. 110 Ct., Miami, Fla.—*Dermatology*

Donald R. Quigley, 34749 Bristol, Livonia, Mich.—*Ob-Gyn*

Donald R. Sipes, 408 Jasmine, Altus AFB, Okla. 73522—*Ob-Gyn*

Edmond M. Brophy, 10103 Crestover, Dallas, Texas 75229—*Ob-Gyn*

David M. C. Hislop, 3205 Belle Court, Royal Oak, Mich.—*Ob-Gyn*

Robert I. Goodman, 33 Field Hospital (U.S. Army Hospital), APO 09801, New York—*Orthopedics*

George M. Bartels, 2332 Perth Dr., Louisville, Ky. —*Ob-Gyn*

James J. LaPolla, 146-08 224th St., Rosedale, N.Y. —*Pediatrics*

Frank W. Govern, 6757 Marshall, Fort Hood, Texas—*Pediatrics*

S. Martin, 1517 McElderry St., Baltimore, Md. 21205—*Pediatrics*

E. G. Lim, 1316 Second St., N.W., Mason City, Iowa 50401—*Radiology*



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David A. Conant, 215 W. Walnut Lane, Philadelphia, Pa. 44—*Urology*

Walter A. Pribe, 4306-6 O'Donnell, Fort Riley, Kan. —*Urology*

Alexander D. Raptou, 111 E. Perimeter Dr., San Antonio, Texas 79227—*Physical Medicine and Rehabilitation*

Ralph E. Wenzel, 114 Pine Circle, Monroe, Ga., 30655—*Student Health, Pharmaceutical Investigation*

#### Internal Medicine

Charles H. Harrison, 1839 24th St., N.E., Washington, D. C.

Charles I. Wabner, 3019 St. John Ct. #7, Columbus, Ohio 43202

Jaime L. Neuman, 2901 S. Parkway, Chicago, Ill.

Bernard E. Levine, 1583 S. Ivy, Denver, Colo.

C. Robert Ruppenthal, 2607 Hampshire Rd., Cleveland, Ohio 44106

Richard F. Runser, 1326 Eastview Ave., Columbus, Ohio 43212

#### Surgery

Alfredo A. Austria, 4253 Hickory Lane, Warrensville Heights, Ohio 44128

Severino T. Sulit, 4289 Skylark Dr., Cincinnati, Ohio 38

Prisco T. Evangelista, 4336 Skylark Dr., Cincinnati, Ohio 38

Jack L. Kelley, 1208 Prospect St., Ann Arbor, Mich.

Samuel Parra, 804 S. 31 St., Temple, Texas

Peter Hutchin, Box 3128, Duke Hospital, Durham, N. C.

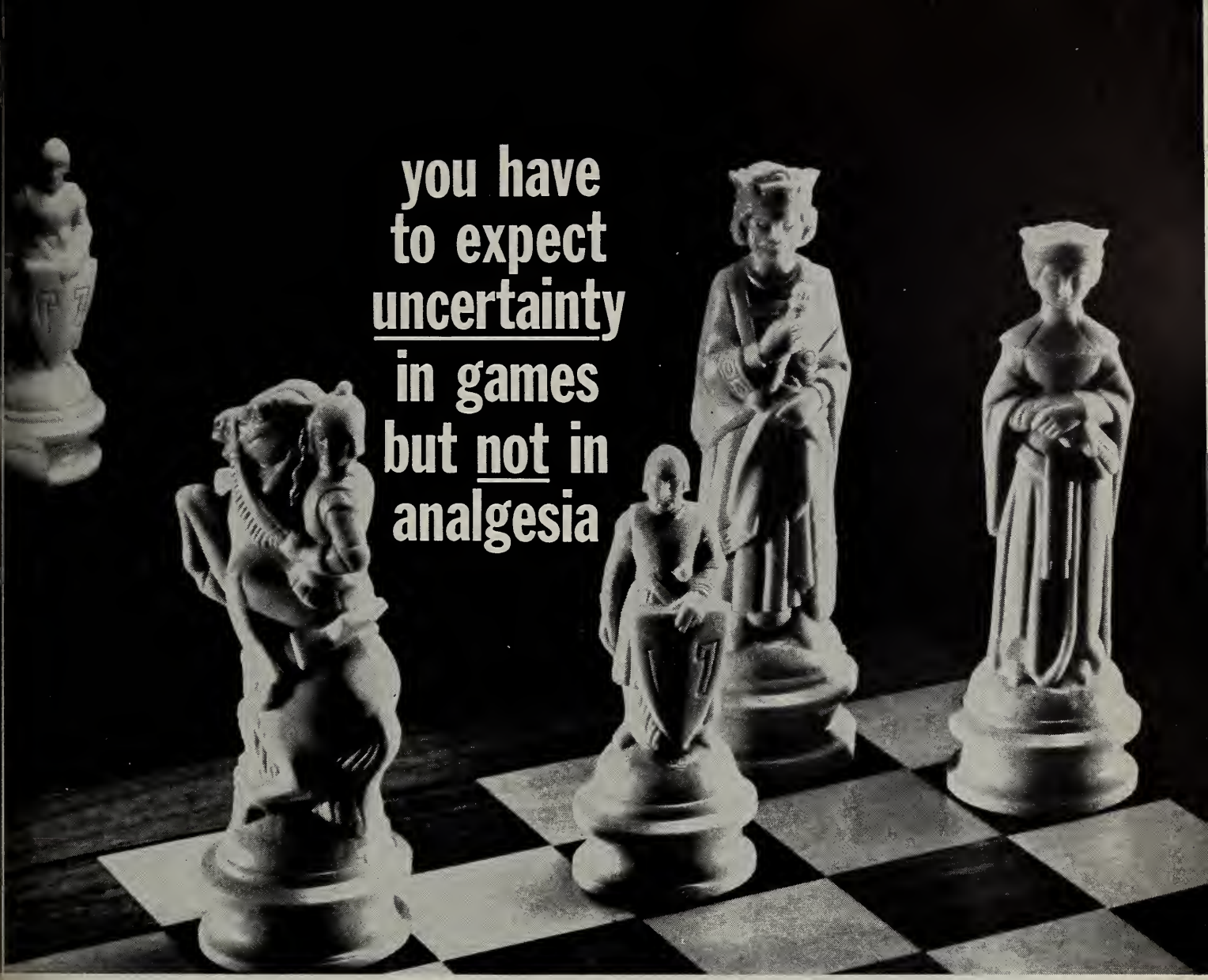
Albert J. Gambarini, 213 Dauntless Lane, Hartford, Conn.

### ADDITIONAL LOCATIONS

Crawford County—ENGLISH—population 700. County trade area of 8,000. One elderly physician and one part-time physician in area. Hospitals located at Paoli, 17 miles distant and Huntingburg 30 miles away. Office of the late N. E. Gobbel available. For further information contact Irvin A. Fahr or Robert Hunt, English.

Warrick County—NEWBURGH—population 1,350. Located five miles from Evansville where hospital facilities are available. For further information contact C. M. Wilhelmus, M.D., Newburgh. ◄

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# ABSTRACTS

## BOOK REVIEWS

### A HISTORY OF PATHOLOGY

Esmond R. Long, Dover Publications, Inc., New York, 1965, $2.00.

*A History of Pathology* follows the development of pathology from the earliest recorded accounts to the present time. Dr. Long, Emeritus Professor of Pathology, University of Pennsylvania, traces our heritage in pathology in a dynamic manner which reflects his encompassing knowledge of the subject as well as his great enthusiasm for medicine.

The history is presented by periods of growth with listings of the principal physicians of the time along with their achievements. The book is not just a procession of names and dates but imparts to the reader an insight into the character of the physicians and the circumstances and times in which they lived.

The paperback edition is well bound and brings the price into the range of the student. An index of subjects and personal names makes the text a handy reference.

Dr. Long's work makes eponyms come alive for the student, pathologist and all physicians interested in medical history.

JAMES J. SULLIVAN, M.D.
Indianapolis, Ind.

### RHEUMATIC FEVER: Diagnosis, Management and Prevention

M. Markowitz, Ann Kuttner and L. Gordis; Vol. II in the series, "Major Problems in Clinical Pediatrics"; W. B. Saunders Co., Philadelphia, Pa., 1965; 242 pages; well illustrated; $7.50.

While I am an internist, the publisher must have been aware of my very personal interest in rheumatic fever. After all, my mother and both my daughters had the disease: to say nothing of two of my wife's sisters! The hemolytic streptococci did not strike down either myself nor my son but my involvement with "Bouillaud's Disease" (see *Am. J. Cardiol.*, 1:4, April, 1958, pp. 517-521) is deep, indeed.

This pocket-sized book has a very plain cover and a disarmingly modest preface even if it bears the Irvington House imprimatur. The scant 200-odd pages are a veritable treasure trove for the most gourmet type reader! Carefully chosen x-rays and splendid diagrams aid in clarifying any ambiguities that may be present. We are enthralled with a beautifully reasoned, splendidly balanced, thoroughly up-to-date exposition of a disease about which we are still uncovering ever newer, previously unsuspected facets.

Twenty pages of references and an excellent index will aid the reader who wishes to understand in more detail some particular aspect of rheumatic fever. The authors have been meticulous in their choice of words; in the entire monograph, I could not find a single discordant note. Not only that:

Continued

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# What is the single most important contribution to drug research?

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when President Washington signed the first U.S. patent law. For patents mean drug progress. For example, of the 604 important drugs introduced worldwide since 1941, the majority originated in the U.S. drug industry. By contrast, a major west European nation, which has no patent protection, contributed one.

How great is the contribution of drug patents? The answer is told in life itself: our children live 10 years longer than we, and need not suffer polio, measles, diphtheria, tuberculosis, rheumatic heart disease, and a dozen other illnesses we grew up fearing. We can expect these benefits to multiply—as long as our patent system remains strong.



**Pharmaceutical Manufacturers Association**
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the verbal economy has been such that practically ALL ramifications of a vast topic have been analyzed concisely, precisely and most understandably.

*Everyone* with any interest whatever in rheumatic fever should acquire a copy of this magnificent monograph. For the ONE book on this topic, it is the logical choice. The authors deserve unstinted kudos for their dedicated labors.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

## Abstracts From Various Literature, Prepared by AMA

### THE SPREAD OF NEOMYCIN-RESISTANT STAPHYLOCOCCI IN A HOSPITAL

P. M. Rountree and M. A. Beard (Royal Prince Alfred Hosp., Sydney, Australia)

*Med. J. Aust.* 1:498-502, (April 3), 1965.

Neomycin-resistant staphylococci of one particular phage type were introduced into a hospital with a burned patient in December, 1963. In the following 10 months, 136 persons were clinically infected with this organism and 67 nasal carriers were found. The course of epidemics in two particular wards is described. Initially, the organism was resistant to penicillin, streptomycin, tetracycline, neomycin and kanamycin. Later, it was resistant also to erythromycin and bacitracin. The strain is similar to new strains of *Staphylococcus aureus* described as causing hospital infection in the United Kingdom. It was identified in six other large hospitals throughout Australia; in all of these, save one, it was neomycin-sensitive.

### THE "HOLD-BACK" MANEUVER AS AN OBSTETRIC HAZARD

C. H. Carter (Sunland Hosp., P.O. Box 3513, Orlando, Fla.)

*Obstet. Gynec.* 25:710, (May), 1965.

Animal studies have shown that delay of respiration by any mechanism for seven minutes or longer produces irreversible brain damage. Manual delay of delivery following crowning of the head at the vaginal outlet is a procedure that has been practiced when circumstances for delivery are not good such as in taxis, emergency rooms, etc. Delayed delivery may produce cerebral anoxia due to beginning separation of the placenta, constriction of the head or cord and other factors. The procedure may also produce brain tears or hemorrhages. Observations are reported on 15 mentally retarded children in whom a delaying technic had been used. The EEG's are positive for anoxia type brain damage. The patients' mental levels varied from severe to mildly retarded; spasticity is noted in many cases. The number of cases seen indicate that this may be a cause of mental retardation.

### FURTHER EXPERIENCE IN USE OF HUMAN ANTIHEMOPHILIC GLOBULIN FOR THE CONTROL OF BLEEDING AFTER DENTAL EXTRACTION IN HEMOPHILIC PATIENTS

R. Biggs et al. (Churchill Hosp., Oxford, England)

*Lancet* 1:969-974, (May 8), 1965.

This report is based on the study of 43 sessions of dental extraction in 38 hemophilic patients from whom a total of 433 teeth were removed under general anesthesia. The purpose of the trial was to determine the minimum treatment required for safety. Human antihemophilic globulin made by the Blood Products Laboratory was the main therapeutic agent. The amount of treatment required was related to the number, position, and type of teeth removed. The effectiveness of treatment was related to the level of factor-VIII activity assayed in the patient's blood. From the experience gained it is possible to predict the amount of treatment required for safety in the majority of cases, and the dosage and duration of treatment varies with the extent of the operative procedure.

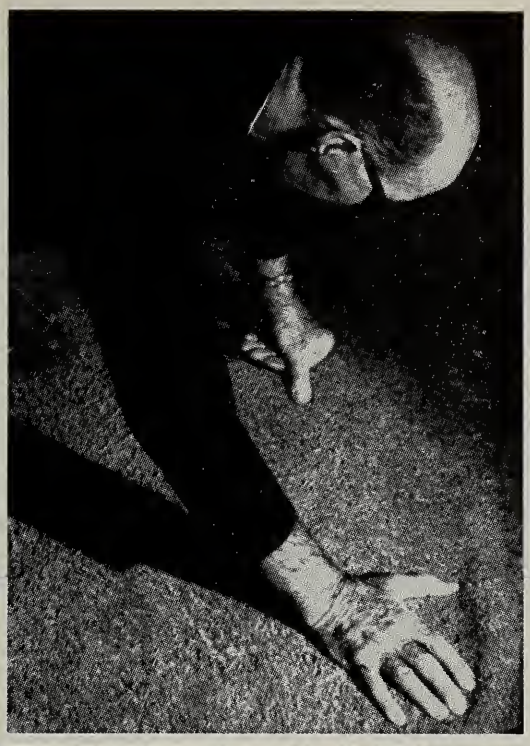
### RESULTS OF CARDIAC RESUSCITATION IN 254 PATIENTS

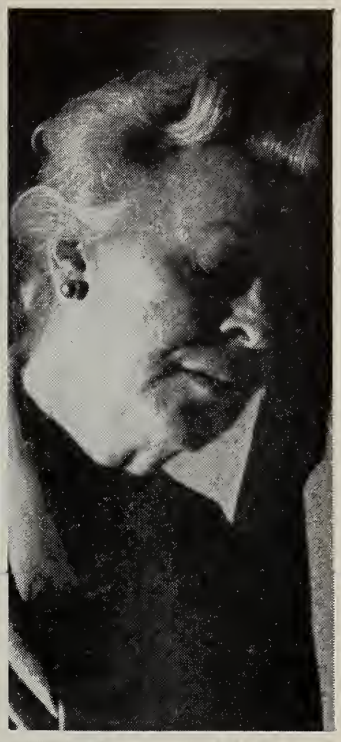
H. J. Smith (Royal Victoria Hosp., McGill University, Montreal) and N. R. Anthonisen

*Lancet* 1:1027-1029, (May 15), 1965.

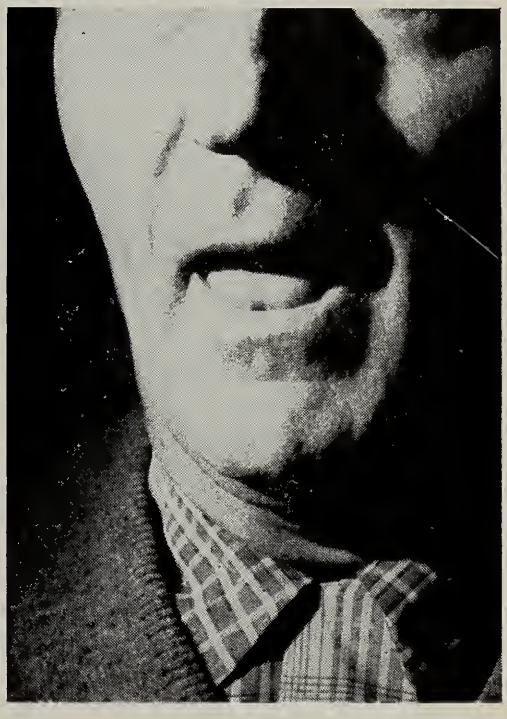
An earlier report reviewed the results of resuscitation in 126 patients in whom cardiac arrest occurred. In the year since, a further 128 patients have been treated. The resuscitation procedure has differed from that of the initial series only in the use of DC defibrillation and of large doses of sodium bicarbonate. Staffs were instructed in the technics of external cardiac massage and artificial respiration. In an emergency, these were applied at once and the cardiac-resuscitation team was summoned. On its arrival, cardiac massage and artificial ventilation were continued; an endotracheal tube was passed if necessary; an intravenous infusion of glucose was set up, and the nature of arrhythmia was determined electrocardiographically. Ventricular fibrillation was treated by direct-current shock and slow arrhythmias and asystole by intravenous isoproterenol. Of the 128 patients, 23 survived and of the total of 254, 40 (or 15.8%) survived. Metabolic acidosis and raised arterial-lactate levels were found in most patients soon after arrest. Correction of the acidosis with intravenous sodium bicarbonate was found beneficial.◄











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- paralysis
- speech difficulties

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**References:** (1) Abstract of Proceedings, Stroke Conference, Chicago (Feb. 14-16) 1963, prepared for use at National Stroke Congress, October 1964. (2) Blouin, L., and Overman, R. R.: Detailed reports in Mead Johnson Research Files.* (3) Gloning, K., and Klausberger, E. M.: Wien. klin. Wchnschr. **70**:145-149 (Feb.) 1958. (4) Whittier, J. R., and Dhrymiotis, A. D.: Angiology **13**:324-327 (July) 1962. (5) Horton, G. E., and Johnson, P. C., Jr.: Angiology **15**:70-74 (Feb.) 1964. (6) Whittier, J. R.: Angiology **15**:82-87 (Feb.) 1964. *Available upon request.

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## *TWO COMPETITIONS ANNOUNCED BY INDUSTRIAL MEDICAL ASSOCIATION*

Competition for a $250 award for the best manuscript submitted by a medical student, intern or resident on any subject pertinent to and concerning occupational health has been announced by the Central States Society of Industrial Medicine and Surgery. The contest closes at midnight on December 31, 1965.

A second competition, open only to residents in occupational medicine, is announced by the Industrial Medical Association. The award, consisting of an embossed scroll, will be presented at the association's annual meeting to the author or authors of a paper published in the open literature on a subject germane to occupational medicine which is judged to be the most outstanding of those submitted. Reprints entered in the competition must be published during 1965 and submitted prior to January 15, 1966.

Both contests will be judged by members of the Committee on Merit in Authorship of the Industrial Medical Association. The criteria will be largely based on clarity, validity, objectivity, originality and style. Complete contest rules may be obtained from: Industrial Medical Association, 55 East Washington St., Chicago, Ill. 60602.

## Dr. Frank Vellios Named Head of I.U.'s Department of Pathology

Dr. Frank Vellios, professor of pathology and director of surgical pathology at the Indiana University School of Medicine, has been named head of the school's Department of Pathology.

He succeeds Dr. Parker Beamer, who resigned last January to accept a position with the University of California.

A native of St. Louis, Mo., Dr. Vellios has been a member of the faculty of the I.U. School of Medicine since 1952. He was educated in the St. Louis public schools and Washington University of St. Louis, receiving the M.D. degree from the Washington University School of Medicine. He received his resident training there, and at the Columbia University College of Physicians and Surgeons in New York City. He taught at Washington University before coming to Indiana, and on leave from that school taught for a year in Thailand.

## *Scholarship Recipients Named by Insurance Medical Research Fund*

The Life Insurance Medical Research Fund announces grants and fellowships for the coming year, amounting to $1.4 million. New research projects are 50 in number. One of these is awarded to Dr. John B. Hickam, Indianapolis, for study of the retinal circulation in man.

The fellowships are awarded to 18 exceptionally promising medical students who are oriented to a career in medical research. The fellowships provide up to six years' training. Gerald R. Yarnell, Indianapolis, a student at the Indiana University School of Medicine is one of the scholarship recipients.

## New SKF Representative

George J. Frangoulis has been assigned to the South Bend, Indiana territory as a professional service representative for Smith Kline & French Laboratories.

Frangoulis recently was graduated from the University of Michigan.

## *Indiana State Board of Health to Work With Armed Forces Rejectees*

The Indiana State Board of Health is cooperating with the U. S. Public Health Service in the Armed Forces Medical Rejectee Program. Approximately 7,500 young men in Indiana will be rejected for military service this year.

Rejectees will be informed of the existence of a counseling service available at local health departments. In the case of remediable defects, the rejectee will be advised of the nature of corrective measures and will be assisted in obtaining proper treatment.

## Dr. Karl Ruddell Elected

Dr. Karl Ruddell, Indianapolis surgeon, has been elected president of the Marion county chapter of the Wabash Valley Association. The association promotes water conservation and flood control along the Wabash.

## *Revised Editions of Books Available From Fire Protection Association*

The National Fire Protection Association announces new and extensively revised editions of its book on "Flammable Anesthetics" at 65 cents per

copy and its Standard No. 76 "Essential Electrical Systems for Hospitals" at 50 cents per copy.

Both publications have been modified to include all the newest information. Orders should be mailed to the Association at 60 Batterymarch St., Boston, Mass. 02110.

## Purdue University to Train New Type Mental Health Workers

Training of a new type of mental health worker will be developed by Purdue University at its Fort Wayne regional campus this fall. John E. True, staff psychologist at the VA Hospital in Cincinnati for the past five years, will be associate director of the curriculum-development and research project.

A two-year associate degree program will be developed to train semi-professional personnel to work directly with patients in comprehensive mental health centers, day-care centers, mental hospitals, schools for the retarded and other situations requiring specially trained personnel.

## *SKF Publishes Manual on Drug Abuse for Law Enforcement Officers*

"Drug Abuse," a manual for law enforcement officers, has been published by Smith Kline & French Laboratories. The book was prepared with the help of an advisory panel of physicians, pharmacists and law enforcement officers.

It discusses the drug groups subject to abuse, the drug abuser and his environment, the illegal traffic in drugs, security measures in the drug industry, drug law, investigation technics and drug identification. Single copies of the manual are available on request from the Law Enforcement Liaison Unit, Smith Kline & French Laboratories, Philadelphia, Pennsylvania 19101.

## PROJECT VIET-NAM Needs Physician Volunteers

PROJECT VIET-NAM is a voluntary organization to promote voluntary medical effort for the people of South Viet-Nam. Teams of 20 physicians will be sent to Viet-Nam for periods of 60 days. Each team will be divided into four groups, each of which will be assigned to a hospital now being operated under the AID program.

Transportation to and from, a nominal per diem, housing, meals and other such needs will be supplied. The American Medical Association urges all its members to consider such service and if interested to write PROJECT VIET-NAM, 2233 Wisconsin Ave., N. W., Washington, D. C. 20007.

## *Wyoming VA Hospital Has Vacancy on Staff for Internist*

The VA Hospital at Cheyenne, Wyoming has a vacancy on its staff for an internist. Starting salary ranges from $8,650 to $12,075, with many fringe benefits.

Anyone interested may write the Chief, Personnel Division, VA Center, 2360 E. Pershing Blvd., Cheyenne 82001.

## Booklet Describes Measures For Control of Rheumatic Fever

Control of rheumatic fever is discussed at length in a 24-page booklet offered by Wyeth Laboratories, Philadelphia. Entitled "Diagnosis, Therapy and Prophylaxis of Streptococcal Pharyngitis in the Control of Rheumatic Fever," the booklet describes rheumatic fever as a continuing problem and "a major catastrophe of childhood."

The importance of accurate diagnosis of streptococcal pharyngitis is discussed from an extensive list of 64 references. Diagnostic methods are outlined along with treatment of choice for controlling strep infection and preventing rheumatic fever.

Copies of the booklet are available for medical and hospital personnel from Wyeth representatives or from Wyeth Laboratories, Box 8299, Philadelphia, Pa. 19101.

## *American College of Chest Physicians Announces Essay Contest*

The American College of Chest Physicians offers three cash awards to be given annually for the best essay prepared by undergraduate medical students on any phase of the diagnosis and/or treatment of chest diseases (heart or lungs).

The first prize will be $500; second prize, $300 and third prize, $200. Each winner will also receive a certificate of merit. A trophy inscribed with the name of the winner and the name of his school will be presented to the winner's school. Since these essay contests were initiated in 1950, cash prizes totaling more than $13,000 have been awarded to students in many parts of the world.

The winners will be announced at the 32nd Annual Meeting of the American College of Chest Physicians, to be held in Chicago, Illinois, June 23-27, 1966.

The official application form, sample copies of the journal, and additional information may be secured by writing Mr. Murray Kornfeld, Executive Director, American College of Chest Physicians, 112 E. Chestnut St., Chicago, Illinois 60611.

## SKF Voluntary Speakers Bureau Spreads Information, Good Will

Since 1959 Smith Kline and French Laboratories have maintained a speakers bureau for the purpose of telling the story of the pharmaceutical industry to the American people. All 405 SK&F field men and 105 home office employees volunteered for this public service enterprise and in six years have given over 10,000 talks all over the United States.

In Indiana 326 talks have been delivered to audiences aggregating over 13,200 persons. The speeches are followed by question and answer periods during which misconceptions are cleared and good will is established for the pharmaceutical industry and for all members of the health team. ◄

# FUTURE MEETINGS, SEMINARS, COURSES

## Cleveland Clinic Announces Course on Treatment Advances

The Cleveland Clinic Educational Foundation will present a postgraduate course entitled "Recent Advances in Medical Treatment" November 3 and 4 at Cleveland.

Registration fee is $30.00. Further information on the course may be obtained by writing the Director of Education, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

## *Diabetes Association of Greater Chicago's Eighth Annual Symposium*

The Diabetes Association of Greater Chicago will conduct its eighth annual symposium on diabetes at the Bigler Auditorium, Children's Memorial Hospital, 707 W. Fullerton, Chicago on Friday, November 12, with registration beginning at 8:30 a.m.

The morning session will be devoted to a symposium on current definitions of the disease, including electron microscopical, biochemical, endocrinological and clinical redefinitions, followed by a panel discussion. In the afternoon there will be a presentation on the prevalence and epidemiology of diabetes, a discussion of psychiatric aspects, and a paper on juvenile diabetes and some of the inferences that may be drawn from the work in this area.

There will be a roundtable discussion at the luncheon recess in the lunchroom of the Children's Memorial Hospital, led by various speakers on the program. Luncheon is by subscription.

Registration is free for members of the Diabetes Association of Greater Chicago or the American Diabetes Association and for medical students and resident house staff members. The fee for nonmembers is $25.00.

Members of the Academy of General Practice may claim hour for hour credit in Category II.

Inquiries may be addressed to: The Diabetes Association of Greater Chicago, 620 N. Michigan Ave., Chicago, Ill. 60611.

## Postgraduate Course on the Treatment of Injuries Offered

The Committee on Injuries of the American Academy of Orthopaedic Surgeons in conjunction with the University of Texas Southwestern Medical School will present a comprehensive postgraduate course on the Treatment of Injuries in Dallas, Texas, at the Marriott Motor Hotel, November 17-20. The program has been arranged by a Dallas committee under the chairmanship of Dr. Charles F. Gregory. The distinguished faculty will consist of six outstanding teachers from out of town and 22 specialists from the medical schools of Texas will take part.

The course is open to all physicians. The registration fee is $75.00. Each registrant will be a guest of the committee for one luncheon and a chairman's reception on Thursday evening, November 18. Residents, interns, and medical students are admitted free by a letter from their chief of service. The course is approved for 30 hours of Category II credit for General Practice.

For further information write Dr. Gregory at 29 E. Madison St., Chicago 60602.

## *Mayo Clinic Postgraduate Course On "Vascular Diseases" Offered*

The Mayo Clinic will conduct a postgraduate course on "Vascular Diseases" on November 18, 19 and 20. Registration is limited to 150.

The registration fee is $5.00; tuition fee is $55.00. Details may be obtained by writing Postgraduate Courses, Mayo Clinic, Rochester 55901.

## International Cancer Congress October 23-29, 1966 in Tokyo

A charter flight and several group flights are contemplated in connection with the IX International Cancer Congress in Tokyo, Japan, October 23-29, 1966, thus substantially reducing the cost of transportation. Members of the immediate family of congress participants will be eligible.

Anyone interested should communicate with Hirsch Marks, M.D., 435 E. 57th St., New York 22, N. Y.

## *International Conference on Alcohol and Traffic Safety*

A global "Who's Who" in the field of alcohol research will be assembled Dec. 6-10 at Indiana University for the fourth International Conference on Alcohol and Traffic Safety.

Advance registrations for the conference indicate the participation of top scientists and professional leaders from Canada, West Germany, the German Democratic Republic, the United Kingdom, Switzerland, Sweden, Poland, the Netherlands, Australia, Yugoslavia and the United States. Additional countries in Europe, Asia and South America are expected in the final tabulation of participants.

For registration or additional information, write Professor Robert F. Borkenstein, Indiana University, Bloomington, Ind.

## Hospital Utilization Committees To Be Discussed At AMA Conference

"Medical Staff in Action—1965, The Utilization Committee," will be the theme of the seventh annual AMA Conference on Medical Services to be

Continued on page 1194.

# An antidepressant designed for the clinical realities of office practice

**As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.**

**Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.**

**This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.**

**And side effects, at recommended dosage, have been infrequent and generally readily controlled.**

**Indications:** 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

**Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

**Precautions:** *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

*Benactyzine hydrochloride*—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

*Meprobamate*—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

**Supplied:** Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.

*Before prescribing, consult package circular.* CD-5749

**Deprol®** meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

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## FUTURES

Continued

held Saturday, Nov. 27 in Philadelphia.

Sponsored by the AMA's Council on Medical Service and its Committee on Medical Facilities, the one-day meeting will be held in the Bellevue Stratford Hotel and will immediately precede the AMA's 19th Clinical Convention.

These experts will review the success of present programs in achieving established goals and will look at the developing needs for, and new demands on, utilization committees.

For additional information write to the Department of Hospitals and Medical Facilities, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

### *Symposium on the Management of the Chronic Disease Patient*

A U. S. Public Health Service sponsored symposium on the Management of the Chronic Disease Patient will be conducted for midwest physicians at Mount Sinai Hospital, Chicago. Five full-day seminars will be as follows:

October 20—Chronic Obstructive Lung Disease
November 3—Cardiac Disabilities
November 17—CVA-Stroke
December 1—Arthritis and Orthopedic Disabilities
December 15—Degenerative Neurological Diseases

For further information write Dr. Aaron M. Rosenthal at the hospital at California Avenue at 15th St., Chicago 60608.

### International College of Surgeons Regents Will Meet in November

The annual regents meeting of the International College of Surgeons will be held Nov. 6 at 1:30 p.m. in the Columbia Club at Indianapolis.

Speakers on the afternoon program will be: Drs. Carl Sputh and George Garceau, both of Indianapolis and Dr. Morris T. Friedell, of Chicago. After dinner speaker will be Frank Edwards, Indianapolis newscaster.

### *"General Practice Review" Program Offered by Medical College of Georgia*

The Medical College of Georgia will present a postgraduate physician education program entitled "General Practice Review" between November 15 and 19 on the school campus in Augusta, Georgia.

All of the instruction will be provided by members of the school faculty and will cover the fields of pediatrics, internal medicine, endocrinology, cardiology, ophthalmology and obstetrics and gynecology.

Registration fee is $80.00 for the full course, or $20.00 a day. Further information may be obtained from the Department of Continuing Education, Medical College of Georgia, Augusta 30902. ◄

## From *The Journal* 50 Years Ago

. . . There are only two ways of knowing the true position of the stomach. First, inflate that stomach with air and palpate with the patient on his feet. In a great majority of cases this is sufficient; you will get the true position in a gross way. The other way of knowing the true position of the stomach is by the Roentgen-ray skiagram or by fluoroscopic study. But I want to emphasize that the position is not so important; it is important in a way, but not so important as function. It is not the position of the stomach, but the way that stomach is performing its functions. I have studied dozens and dozens of stomachs with the greater curve lying upon the symphysis, and yet these stomachs were performing their function admirably. If a patient shows gastric symptoms, the conclusion the average practitioner would jump to is the fact that the symptoms come from gastroptosis, when they are probably reflexes, as we know that a great majority of gastric symptoms are reflex. So do not jump to the conclusion that because you find the stomach down, the symptoms are caused from the organ being down.

These cases must be studied, and we must not lose sight of function. If you find a stomach down, and it is performing its functions, the emptying time is normal, the chemistry is all right, you find no indications of organic disease, you must go still farther and find the cause of your patient's trouble. . . . "The Position of the Normal Stomach, with Observations on the Movements of the Diaphragm," Burton D. Myers, M.D., *JISMA*, October, 1915.

# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—August, 1965

| Disease | Aug. 1965 | Jul. 1965 | Jun. 1965 | Aug. 1964 | Aug. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 890 | 1077 | 1575 | 848 | 1019 |
| Chickenpox | 38 | 110 | 304 | 28 | 40 |
| Conjunctivitis | 127 | 96 | 156 | 81 | 48 |
| Diphtheria | 0 | 0 | 0 | 0 | 0 |
| Dysentery, Unspecified | 89 | 40 | 53 | 51 | 270 |
| Gonorrhea | 357 | 317 | 443 | 351 | 323 |
| Impetigo | 244 | 156 | 143 | 240 | 135 |
| Infectious Hepatitis | 43 | 47 | 52 | 24 | 47 |
| Infectious Mononucleosis | 27 | 38 | 40 | 15 | 14 |
| Influenza | 194 | 905 | 199 | 283 | 105 |
| Measles (Rubeola-Rubella) | 123 | 144 | 629 | 133 | 111 |
| Meningitis, Meningococcal | 1 | 3 | 7 | 3 | 0 |
| Meningitis, Other | 5 | 3 | 6 | 4 | 7 |
| Mumps | 70 | 116 | 324 | 158 | 86 |
| Pertussis | 11 | 10 | 13 | 29 | 62 |
| Pneumonia | 112 | 124 | 182 | 118 | 64 |
| Poliomyelitis | 0 | 0 | 0 | 1 | 0 |
| Streptococcal Infection | 321 | 421 | 437 | 345 | 219 |
| Syphilis | | | | | |
| Primary & Secondary | 3 | 1 | 92 | 4 | 1 |
| All Other Syphilis | 88 | 81 | 7 | 109 | 100 |
| Tinea Capitis | 7 | 16 | 14 | 6 | 3 |
| Tuberculosis (Active) | 114 | 75 | 125 | 110 | 142 |


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# County, District News

## Eleventh District

New president of the Eleventh District Medical Society is Dr. Donald W. Ferrara, Peru; re-elected secretary-treasurer was Dr. Max M. Earl, Kokomo. Dr. Lowell Hillis, Logansport was re-elected alternate councilor and Dr. John Bowers, Kokomo, was re-elected to the Blue Shield board. The 1966 meeting will be at Kokomo.

## Boone

The Boone County Medical Society met Sept. 7 at Lebanon to hear Field Secretary Howard Grindstaff speak on various legislative matters.

## Clinton

Dr. Lee Dupler, Frankfort, spoke on "Chronic Bronchitis" at the Aug. 24 meeting of the Clinton County Medical Society. There were 10 members present at the meeting.

## Dearborn-Ohio

"Fluoridation" was the topic chosen by two dentists when they spoke at the Sept. 2 meeting of the Dearborn-Ohio County Medical Society. Sixteen members attended.

## Huntington

The Huntington County Medical Society met Sept. 2 at the Huntington County Hospital and discussed the resolutions which are to be presented at the ISMA annual convention.

## Jay

Thirteen members of the Jay County Medical Society met Sept. 1 with Field Secretary Grindstaff as speaker. Dr. J. S. Fitzpatrick was named delegate and Dr. William H. Cripe, alternate delegate.

## Jefferson-Switzerland

Dr. John J. Robbins, of Louisville, Ky., spoke on the topic of Urology at the Sept. 7 meeting of the Jefferson-Switzerland County Medical Society.

## Johnson

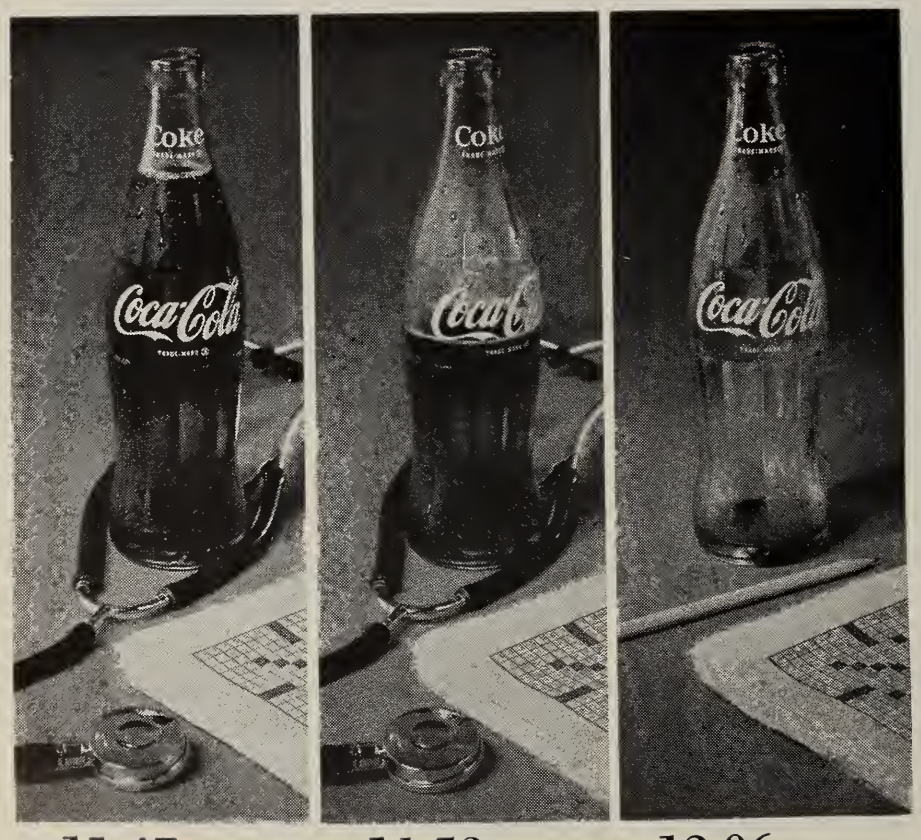
Thirty-two members of the Johnson County Medical Society met with Field Secretary Robert Amick as guest Sept. 8.

## Lawrence

New officers of the Lawrence County Medical Society are: Drs. Richard P. Austin, president; John W. Reuter, president-elect and Glen D. Ley, secretary-treasurer. All of the new officers are from Bedford.

## Vanderburgh

Dr. Lowell I. Thomas and Mr. Richard Kilborn of Indiana Blue Shield discussed Blue Shield Resolution #26 with the Vanderburgh County Medical Society at their meeting Sept. 14 in Evansville. ◄


The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke TRADE-MARK ®

# Deaths

## Joe D. Boughman, M.D.

Dr. Joe D. Boughman, 50, a physician at Kokomo for 20 years, died Aug. 15 there.

A 1941 graduate of the I.U. School of Medicine, Dr. Boughman was a member of the Howard County Medical Society. He was an Army veteran of World War II, serving in France and Germany with the Medical Corps.

## Edgar C. Davis, M.D.

Dr. Edgar C. Davis, Muncie ear, eye, nose and throat specialist, died August 19 at the age of 74.

Graduated from the I.U. School of Medicine in 1919, Dr. Davis had been a physician at Muncie since 1925. He was a Senior Member of ISMA; a member of the Delaware-Blackford County Medical Society, and served on the staff of Ball Memorial Hospital.

## Allen A. Norris, M.D.

Dr. Allan A. Norris, Elkhart physician for 50 years, died Sept. 11 at his home. He was 90.

Dr. Norris was graduated from Rush Medical College in 1906. He was a Senior Member of ISMA and a member of the ISMA 50-Year Club. Dr. Norris, a general practitioner, had been retired for some years. He was a member of the Elkhart County Medical Society.

## Eldon R. Ropp, M.D.

Dr. Eldon R. Ropp, 73, Oakland City general practitioner, died Aug. 8.

A World War I veteran, Dr. Ropp was graduated from the I. U. School of Medicine in 1921 and had practiced in Oakland City for 40 years. He was a Senior Member of ISMA and a member of the Gibson County Medical Society.

## Walter L. Straughan, M.D.

Dr. Walter L. Straughan, a third-generation physician, died Aug. 13 in Culver Hospital at Crawfordsville. He was 86 years old.

A 1902 graduate of the old Indiana Medical College, Dr. Straughan began the practice of medicine in Waveland in his father's office. He went to Crawfordsville in 1919 as assistant medical director of the Ben Hur Life Association and in 1934 was appointed medical director, a post he held until his retirement in 1950. He was a member of the Montgomery County Medical Society and the ISMA 50-Year club.

## Harrison S. Thurston, M.D.

Dr. Harrison S. Thurston, retired Indianapolis physician, died Aug. 6 in the Wabash County Hospital at the age of 88.

A native of Summitville, Dr. Thurston was graduated from the old Indiana Medical College in 1904. He was a reserve officer in the Medical Corps in World Wars I and II and was a physician in Indianapolis 50 years before he retired and moved to North Webster. He was a member of the Marion County Medical Society and the ISMA 50-Year Club.

## Leo P. Van Rie, M.D.

Dr. Leo P. Van Rie, 81, practicing physician and surgeon in Mishawaka for 52 years, died there Aug. 17.

Dr. Van Rie was born in Mishawaka and was graduated from Northwestern University Medical School in 1911. He began his practice in Mishawaka in 1912. He was a member of the ISMA 50-Year Club, the St. Joseph County Medical Society and was on the staff of both the St. Joseph's Hospital of Mishawaka and the St. Joseph's Hospital of South Bend. ◄

# Association News

## EXECUTIVE COMMITTEE

September 11, 1965

Meeting called to order at 3:00 p.m. by the chairman, Dr. Ralph Everly, at which time he introduced Glen V. Ryan, M.D., president of the Blue Shield Board of Directors, and Mr. Richard Kilborn, assistant executive vice-president of Blue Shield.

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D.; Joe M. Black, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal;* Robert Hollowell and Ralph Hamill, attorneys, and James A. Waggener, executive secretary.

Dr. Ryan said he had asked for appearance before the committee for the purpose of having Mr. Kilborn discuss two matters: (1) the role which Blue Shield might play in the administration of the Medicare program under PL 89-97, and (2) proposal which had been made to Blue Shield concerning establishment of a voluntary retirement plan for physicians receiving payments from Blue Shield.

Mr. Kilborn reviewed the activities of the Blue Shield Commission with the Department of Health, Education and Welfare concerning the implementation of PL 89-97. He also referred to the action of the AMA Board of Trustees which encouraged Blue Shield to accept the responsibility as fiscal administrator of this new federal program.

Following discussion of this matter, upon motion of Drs. Neumann and Hoyt, it was voted that this matter be referred to the Council with the recommendation that if and when Blue Shield is approached to act as fiscal administrator in Indiana, they be permitted to do so. Motion carried.

Concerning the matter of establishment of a voluntary retirement plan through Blue Shield, upon motion of Drs. Neumann and Hoyt, the Blue Shield board was given permission to investigate thoroughly the provisions of this idea and to report their findings back to the Executive Committee and the Council.

Upon motion of Drs. Larson and Neumann, minutes of the meeting of July 17, 1965, were approved as distributed.

### Membership Report:

| | |
|---|---|
| Number of members as of December 31, 1964 | 4,365 |
| 1965 members as of August 31, 1965 | 4,365* |
| Number of members as of August 31, 1964 | 4,335 |
| Gain over last year | 30 |
| Number of AMA members as of August 31, 1965 | 4,262 |
| Total 1964 AMA members as of August 31, 1964 | 4,231 |
| Gain over last year | 31 |
| 1965 AMA members: Dues paying | 3,727 |
| Exempt, but active | 535 |
| | 4,262 |
| Number who have paid state dues but not AMA dues as of August 31, 1965 | 103 |

* Includes 302 senior and 3 honorary members

### Headquarters Office

The secretary asked for a policy concerning payment of councilors' expenses and upon motion of Drs. Neumann and Olvey, it was voted that councilors should be reimbursed for mileage, plus their hotel room expenses.

Request of the University of Louisville School of Medicine for use of the mailing list to notify physicians of a postgraduate program was approved on motion of Drs. Larson and Neumann.

The secretary requested the committee to establish a policy concerning the use of the association mailing list inasmuch as this is now situated in the headquarters office. Upon motion of Drs. Neumann and Larson, the price of $20.00 was established for a strip list, and the association will not address envelopes for other organizations.

The secretary reported on correspondence he had had with Encyclopaedia Britannica concerning a mailing which had been made to Indiana physicians and this was accepted for information.

The secretary read a letter from Dr. Maurice E. Glock in which he included a check in the amount of $350.00 for deposit in the kitchen fund for the building, and upon motion of Dr. Neumann, taken by consent, the secretary was instructed to accept the contribution and to express the thanks of the association to both Dr. Glock and to Dr. Fred Brown for this gift.

### Treasurer's Office

The report of the treasurer was accepted on motion of Drs. Neumann and Rifner.

### Annual Convention, October 12-14, 1965, Indianapolis

Plans for the president's luncheon and the final meeting of the House of Delegates were discussed and final arrangements for these events were left in the hands of the president and the secretary.

On motion of Drs. Larson and Olvey, the same individuals as were invited to the president's luncheon in 1964 are to be invited to the 1965 president's luncheon.

Request of the Commission on Public Information for approval to make six awards to the communications industry was approved on motion of Drs. Larson and Black.

It was also stated that a recommendation should be made to this commission that in the future, awards classifications should be established so as not to necessitate the giving of an award to every applicant for this recognition.

The secretary reported that Dr. Kendrick, entertainment chairman for the 1965 meeting, had stated that in his opinion the attendance at the Gaslight Party this year would be almost double what it was in 1964 and therefore Dr. Kendrick felt that the New York Gaslight Club should be brought in, in addition to the Chicago Club. Upon motion of Drs. Black and Neumann, the committee is to be authorized to bring in both the Chicago and the New York clubs.

Upon motion of Drs. Neumann and Larson, the resolution prepared regarding PL 89-97 dealing with relationships between physician and patient is to be referred to the Council with the recommendation that the Council refer it to the House of Delegates and seek its approval.

The secretary reported on the reaction of the Indiana Cancer Society and the Indiana Heart Association regarding their exhibiting at the state meeting.

## Legislation

*National*: The secretary reviewed for the committee the status of Medicare, the AMA activities and actions taken by the 1964 House of Delegates.

A proposal from the Commerce Clearing House for the association to purchase guide books on Medicare and Social Security for distribution to the members at a cost of some $3,000.00 was turned down by consent.

The bulletin of the College of American Pathologists concerning their activities for transfer of fees from hospital charges to individual charges was reviewed.

## Organization Matters

The secretary reviewed additional correspondence received from hospitals regarding advertising for interns in the Student AMA.

The secretary reported acknowledgment from the State Board of Medical Registration and Examination of the resolutions sent to them by the Executive Committee and as adopted by the Indiana Academy of Ophthalmology and Otolaryngology.

The secretary also reviewed the new regulations for implementing the new licensure laws as adopted in the 1965 session of the General Assembly.

The secretary and the attorney reviewed the action of the Attorney General in which he ruled that chiropractors are entitled to use the word "physician" and upon motion of Drs. Neumann and Rifner, the attorney was instructed to take all necessary steps to change this opinion.

The secretary reported on the correspondence with the attorney and his review of the medical report form used by some insurance companies for driver insurance and by consent, it was agreed that the attorney's opinion shall be published in *The Journal* so that all physicians will be aware of the dangers they face in completing this form.

The secretary and the attorney reported on the proposed rewrites of the regulations of the Hospital Licensing Council and following discussion, it was taken by consent that two of these regulations should be rewritten and brought back to the committee.

The various actions taken by the Council were reviewed and upon motion of Drs. Neumann and Rifner, the House of Delegates is to be asked to reconsider the action taken by the House in 1944 in which they approved the St. Paul Mercury Insurance Company as the official carrier of malpractice insurance for the physicians of Indiana.

A letter from Dr. Howard Jackson asking permission to bring his Explorer Scout troop for a tour of the state medical association convention was reviewed and the secretary by consent was instructed to notify Dr. Jackson that any day would be permissible.

A letter from the Los Angeles County Medical Association was reviewed and inasmuch as action had already been taken by the AMA, no action was considered necessary.

A letter from the State Board of Health, in which it was requested that the association sign an agreement to carry on the maternal and mortality study in conformance with the law enacted by the 1965 session of the legislature was approved and the executive secretary was instructed to sign for the association. This action was taken on motion of Drs. Larson and Rifner.

Letters from the Metropolitan Life Insurance Company, the Veterans Administration, Dr. E. T. Edwards and Equitable of Iowa were received for information.

A letter from the Department of State inviting the association to attend a Regional Foreign Policy Conference in Flint, Michigan, September 22, was read. It was agreed that no official representative would be sent.

Correspondence concerning a matter in Dubois county was reviewed and by consent it was agreed the attorney should answer this correspondence.

For the information of the committee, Dr. Neumann reviewed the meeting of presidents and presidents-elect of state medical associations held in Chicago August 21.

A letter from the Illinois State Medical Society was received for information.

Action of the Louisiana State Medical Society concerning physicians signing non-discrimination clauses was reviewed and on motion of Drs. Rifner and Larson, the Executive Committee is to propose a similar resolution at the October meeting of the House of Delegates.

A letter from the AMA to Dr. Lee concerning mental health activities was reviewed for the information of the committee.

An announcement from Purdue University concerning the establishment on their Fort Wayne campus of a new department to teach psychology was reviewed for the information of the committee.

Several letters concerning nominations to be made at the interim meeting for various offices in the American Medical Association were reviewed for the information of the committee.

Dr. Olvey reported on a conversation he had had with Dr. Bibler concerning the State Fair exhibit.

On motion of Drs. Rifner and Black, $500.00 is to be given to the Indiana Chapter of the Student AMA to assist in defraying expenses of their delegates to a meeting in California.

A request for the Executive Committee, as the advisory committee to the Indiana Medical Assistants Association, to express its opinion on a proposal for a disability income program was received. After reviewing the plan, the medical assistants group is to be advised that the Executive

Committee would recommend that they delay specific action on this proposal until such time as they have had an opportunity to investigate other plans.

## The Journal

The editor of *The Journal* reported on the activities of the State Medical Journal Advertising Bureau, its gross volume and the standing of Indiana compared to other journals. This was received as information.

It was pointed out that inasmuch as *The Journal of the Indiana State Medical Association* was now a stockholder in the State Medical Journal Advertising Bureau that the state medical association should designate someone to act as its proxy. On motion of Drs. Black and Rifner, Dr. Frank Ramsey is to be appointed as proxy for Indiana.

## Future Meetings

The secretary announced a special called meeting of the American Medical Association House of Delegates for October 2 and 3 and that the AMA had moved the meeting originally scheduled for October 16 and 17 to October 1.

An invitation for the association to send a representative to the AMA 16th National Conference on Disaster Medical Care in Chicago, October 30-31, 1965, was turned down.

A notice of the annual meeting of the Indiana State Chamber of Commerce, to be held in Indianapolis November 11 was reviewed and it was the impression of the committee that Dr. Don Wood would probably attend this meeting.

A notice of the AMA National Symposium on VD Control, to be held in Chicago November 20, was reviewed. It was agreed that we would not send an official representative. It was thought that one of the doctors from the State Board of Health would attend this meeting and could act as our representative.

A notice that the American Medical Association would convene at 2:00 p.m., Sunday, November 28, 1965, at Philadelphia, was read.

Notice of the AMA 2nd National Voluntary Health Agencies meeting, to be held in Chicago, February 16-17, 1966, was read. This matter is to be brought up again at the December meeting of the Executive Committee.

There being no further business, the committee adjourned to meet again on October 1, 1965, in Chicago. ◄

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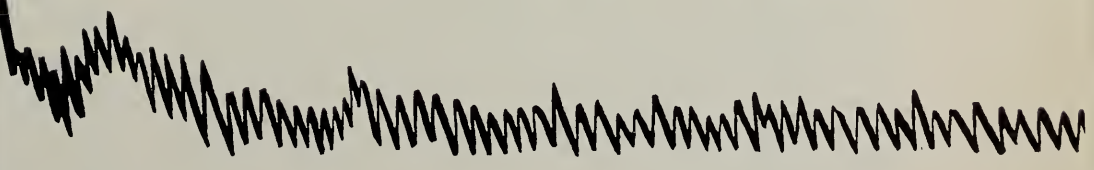
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NOVEMBER 1965

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication
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EDITORIAL AND ADVERTISING INFORMATION

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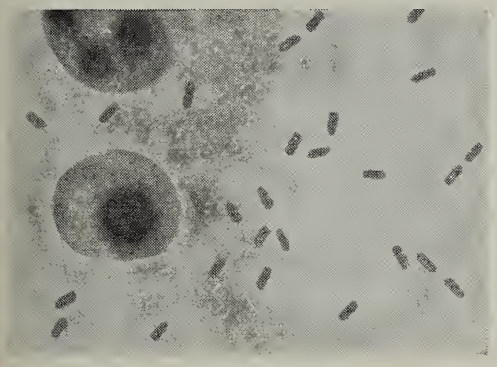
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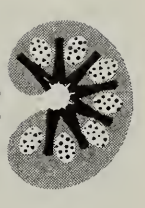
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**References:** (1) Carroll, G.: Urologists' Letter Club, June 1, 1964. (2) McDonald, D. F., and Short, H. B.: Address to the Fourth Interscience Conference on Antimicrobial Agents and Chemotherapy, New York, Oct. 26-28, 1964.

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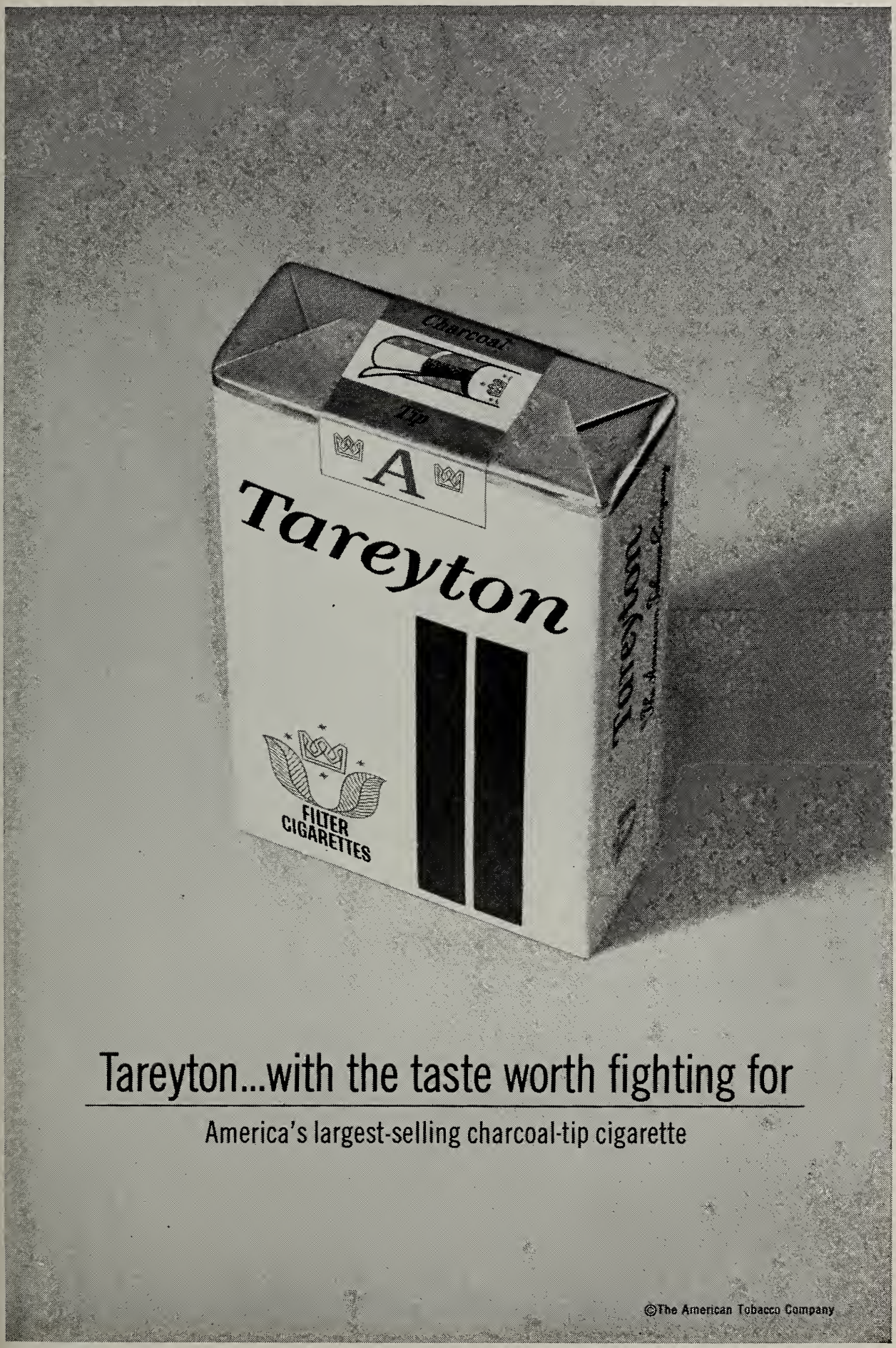
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| 8. | Lowell Painter, Winchester | Paul W. Sparks, Winchester | Muncie, June 1, 1966 |
| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | May 19, 1966 |
| 10. | Michael Shellhouse, Gary | Edward J. Dierolf, Gary | |
| 11. | Donald W. Ferrara, Peru | Max M. Earl, Kokomo | Kokomo, Sept. 21, 1966 |
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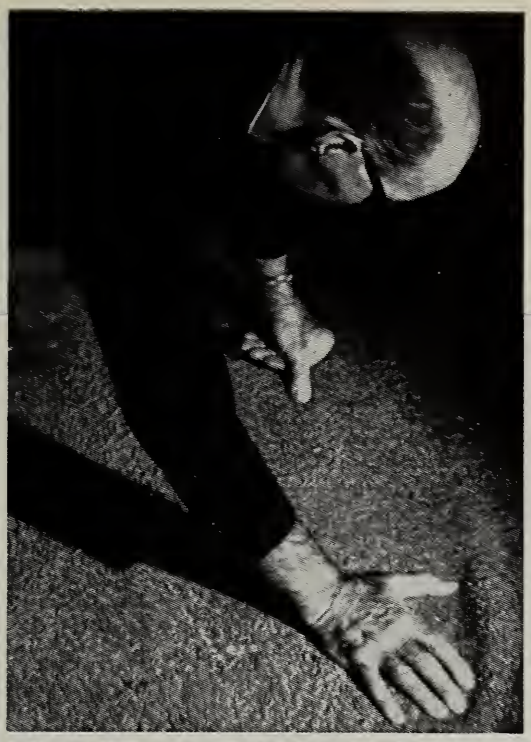
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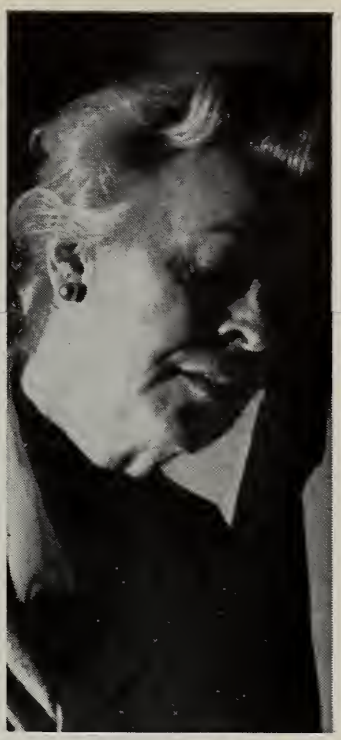


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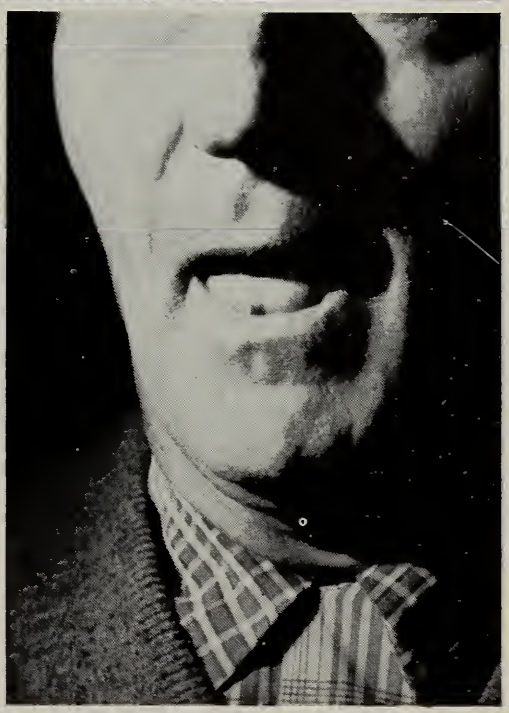
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**References:** (1) Abstract of Proceedings, Stroke Conference, Chicago (Feb. 14-16) 1963, prepared for use at National Stroke Congress, October 1964. (2) Blouin, L., and Overman, R. R.: Detailed reports in Mead Johnson Research Files.* (3) Gloning, K., and Klausberger, E. M.: Wien. klin. Wchnschr. **70**:145-149 (Feb.) 1958. (4) Whittier, J. R., and Dhrymiotis, A. D.: Angiology **13**:324-327 (July) 1962. (5) Horton, G. E., and Johnson, P. C., Jr.: Angiology **15**:70-74 (Feb.) 1964. (6) Whittier, J. R.: Angiology **15**:82-87 (Feb.) 1964. *Available upon request.

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This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D.C.–President Johnson has signed into law a modified version of the controversial, so-called DeBakey legislation authorizing establishment of regional cooperative programs of research, training and related patient care in the fields of heart disease, cancer, stroke and related diseases.

A total of $340 million in federal funds will be available during the next three years to help universities, medical schools, research centers and other public or nonprofit institutions, such as hospitals, and agencies in (1) planning, (2) conducting feasibility studies and (3) operating pilot projects.

The legislation was amended in the House, as recommended by the American Medical Association, to make it less objectionable to the medical profession. Dr. James Z. Appel, president of AMA, said the some 20 House amendments were substantial and should "allay many of the fears the medical profession had about the original bill."

But even so, the AMA could not support the amended legislation, Dr. Appel said, "because we believe it still introduces an undesirable concept."

The original bill called for establishment of regional medical complexes and would have included "other major diseases."

As enacted into law, the programs are to be carried out "in cooperation with practicing physicians." Patient care is limited to that "incident to research, training or demonstrations." No patient can receive such treatment except on referral of a practicing physician.

Construction is limited to remodeling and renovation of buildings and replacement of obsolete equipment.

The Surgeon General of the Public Health Service is designated as the official responsible for final approval of federal grants under the program. However, he can act only upon the recommendation of a national advisory council. And an application for a federal grant first must be approved by a local advisory committee. Both the national and local committees must include practicing physicians.

Present federal plans call for starting eight regional programs during the first year and 17 more during the next two years. As of this writing, none of them had been announced.

## HEW DOES NOT REQUIRE NON-DISCRIMINATION PLEDGES

The Department of Health, Education and Welfare has ruled that physicians are not required to sign racial non-discrimination pledges in order to receive payment for treating federal-state welfare patients.

Continued




# An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

# Miltown® (meprobamate)

**Indications:** 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

**Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

**Precautions:** Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Usual adult dosage:** One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

**Supplied:** In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

*Before prescribing, consult package circular.*

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*Cranbury, N.J.*

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The ruling followed protests of some state medical societies and individual physicians when some state health departments interpreted the new Civil Rights Act as requiring the signing of such a pledge. The societies and physicians protested that such a pledge would constitute an unnecessary federal interference in the patient-physician relationship.

The recent special meeting of the AMA House of Delegates adopted a resolution pointing out that non-discrimination conditions under the Principles of Medical Ethics and "willingly self-imposed by the medical profession far exceed any pledge of this nature demanded by a federal bureaucracy."

## HOUSE DEFERS LEGISLATION "LIBERALIZING" KEOGH LAW

The House Ways and Means Committee has postponed until next year consideration of legislation that would liberalize the so-called Keogh law. The present law permits physicians and other self-employed persons to defer income taxes on a maximum of $1,250 a year set aside in a retirement fund. A bill before the committee would increase the maximum to $2,500 a year.

## POLIO, DIPHTHERIA CASES DOWN

The Public Health Service reported only 35 cases of polio during the first 34 weeks of this year, a record low for the period. For the same period last year, 65 cases were reported.

During the same period this year, only 96 cases of diphtheria were reported. This figure compared with a five-year median of 244 cases in the same number of weeks.

## NEW PHS SURGEON GENERAL ANNOUNCED

Dr. William H. Stewart, 44-year-old Public Health Service career officer, is the new PHS Surgeon General.

He succeeded Dr. Luther Terry who resigned to become vice-president of the University of Pennsylvania.

Recognized as an expert in the field of public health administration, Dr. Stewart had headed the National Heart Institute since last August. For the previous two years, he served as assistant to the special assistant to the HEW Assistant Secretary for Health and Medical Affairs.

After being graduated from the Louisiana State University School of Medicine, he served in the Army Medical Corps from 1946 to 1948. He gave up a pediatric practice in Alexandria, La., in 1951 to join the PHS Commissioned Corps.

## MORE PHYSICIANS TO BE DRAFTED

A total of 1,529 physicians will be drafted during the first part of next year. The military needs in Viet Nam made necessary an increase in the doctors' draft over the 852 called last January and the 1,000 in January, 1964.

The 1966 draft will cover physicians who completed their internships from two to five years ago, many of whom now are in private practice.

All those drafted will be given an opportunity to accept officer commissions before induction.

Of the quota, 949 will be for the Army, 266 for the Navy and 320 for the Air Force.

Continued

*when treatment might precipitate a problem with monilia*

*especially in diabetics or debilitated patients*

*and in patients with a history of fungal overgrowth—during pregnancy—patients on steroids who require antibiotics—the elderly.* The antimonilial specificity of Nystatin plus the extra benefits of DECLOMYCIN Demethylchlortetracycline allow lower mg intake per dose per day, the option of b.i.d. dosage, higher activity levels, 1-2 days' "extra" activity.

*Side Effects* typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

*Average Adult Daily Dosage:* four divided doses of 1 capsule each or two divided doses of 2 capsules.

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DECLOMYCIN® Demethylchlortetracycline HCl 150 mg and Nystatin 250,000 units/CAPSULES LEDERLE

**with the option of b.i.d. dosage**



In addition to the physicians, 350 dentists and 100 veterinarians will be drafted.

### COMMUNITY MEASLES VACCINATION URGED

The Surgeon General's Advisory Committee on Immunization has recommended community vaccination programs against measles.

The committee said that measles is one of the most important causes of serious illness in children and recommended that continuing "maintenance" programs aimed at vaccinating children about one year of age be established in all communities.

"Additionally, consideration should be given to the concept of full immunization of all children entering schools, nursery schools, etc., since measles transmission in the community occurs principally among children in such settings," the committee said.

"Widespread immunization may be achieved through routine and intensive programs conducted in physicians' offices and immunization clinics in both public health and private medical practice. In some instances, mass community-wide vaccination programs may prove practicable in communities or segments of communities in which immunization levels achieved through routine practice are known to be low.

"If community-wide programs are conducted, cognizance must be taken of the fact that such programs are necessarily more complex than those involving oral polio vaccine, for example, since measles vaccines must be parenterally administered." ◄

## From *The Journal* 50 Years Ago

The story is told of a professor of physiology who asked a medical student what was the function of the spleen and received the reply "I did know but have forgotten." The professor said: "It is a great pity you have forgotten, because no one else has ever known."

The idea that the spleen is an obsolete organ of little function is not tenable, as Eccles has pointed out. The outstanding fact in a retrogressing organ is the reduced blood supply. The tonsils, for example, were at one time supposed to be retrogressive, but the fact that the tonsil has five sources of blood supply shows that it is not obsolescent, yet it is not essential to life and when diseased has great potentiality for harm. This is quite analogous to the spleen.

It would appear that the spleen removes from the circulation not only cellular elements of definite food value, but also, when unable to care for these products, sends them to the liver for elaboration into energy-producing substances, on the one hand, and destruction of various toxic agents on the other, that nothing of value may be eliminated and that dangerous products, wherever produced, may be rendered harmless. . . . "The Relation of the Spleen to Certain Anemias," William J. Mayo, M.D., *JISMA*, November, 1915.

to help relieve pain
in common
anorectal disorders

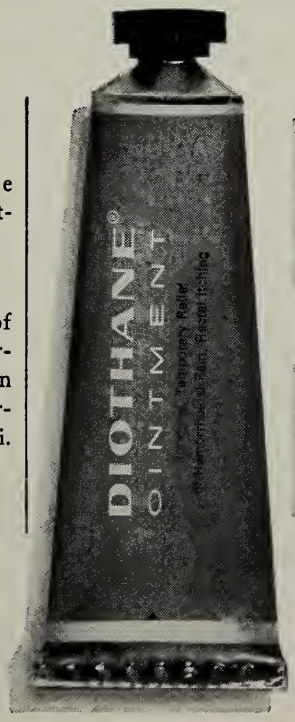
# "non-caine"
# Diothane®

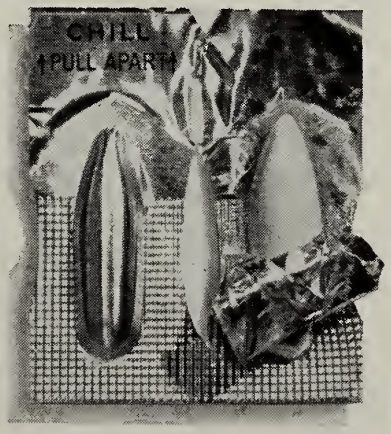
Diothane—with its chemically distinct "non-caine" anesthetic agent diperodon—provides effective temporary topical anesthetic and emollient actions for soothing relief of anorectal pain. Anesthetic activity is effective and relatively prolonged; sensitization is infrequent. Reports to Merrell on 1,500 patients treated pre- and postoperatively with Diothane Ointment, indicate only 22 developed local skin reactions. Reactions to Diothane have been burning or stinging sensations and a few cases of allergic manifestations. An additional advantage: Diothane Ointment and Suppositories are mildly antiseptic. Prescribe or recommend either form...both are now available.

**IOTHANE OINTMENT**

OMPOSITION:
perodon 1.0%; oxyquinoline nzoate 0.1% in a special oint-ent base.

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ovides temporary palliation of in that may result from hemor-oidectomy and from common orectal disorders such as hemor-oids, anal fissures, pruritus ani.



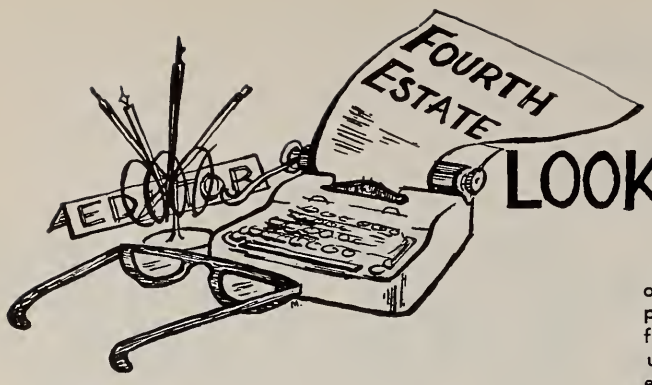

**DIOTHANE SUPPOSITORIES**

COMPOSITION:
Each suppository, weighing approximately 2.6 Gm., contains diperodon 1.0%; urea 10.0%; oxyquinoline benzoate 0.1% in a special hydrophilic suppository base. A unique shape keeps the suppository in intimate contact with mucous membranes.

INDICATIONS:
Provide for temporary palliation of pain caused by hemorrhoids and pruritus ani.

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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Strengthens Medical Center Bid

The data developed on the availability of physicians for teaching in the proposed second Indiana medical center is highly important to the effort to have the facility established in South Bend.

The data, assembled by the Medical Center Liaison Committee of the St. Joseph County Medical Society, shows that 270 Northern Indiana physicians are prepared to teach and engage in related activities 750 hours a month if the school is situated here.

In making the report, Dr. Abner H. Levkoff noted that the physicians lining up for participation are the authors of 434 official medical articles and are specialists in all fields of medicine.

He could well say: "The number of publications shows quite clearly that we have in northern Indiana a tremendous reservoir of academically-oriented medical people. This is an important advantage in the establishment of a medical school."

The facts as established by the committee are impressive. They should strengthen greatly the case for locating the center in South Bend. The medical society has rendered another valuable service to this community. — *South Bend Tribune,* Aug. 22, 1965.

**Metatarsal Bars**
(inserted between shoe sole)

Handmade of leather as to the angle of metatarsal heads, most effective — out of sight. If a depressed metatarsal, corn or callus exists, a plug can be applied for relief.

Prescriptions and Referrals invited

**IRVIN and HUBERT HEIDENREICH**
**HEIDS HEALTH SHOE STORE**
411 N. Illinois St. — Indianapolis, Ind.

## Medical Shortage

It has been freely predicted that the federally sponsored health insurance program will intensify an existing shortage of doctors, nurses and other health personnel. Federal experts do not deny this; Surgeon General Terry recently told a group that "we will inevitably continue to confront for some time shortages of both health personnel and facilities" in administering medicare.

There has been some inclination to interpret this as a flaw in the health program. The trouble goes much deeper than that. For many years, the United States has not been training enough doctors; for years there has been a shortage of nurses. The causes of this — among other things, the overly restrictive policies of organized medicine — must be considered, and steps must be taken to alleviate the situation. It is clear that medicare will put more pressure on existing personnel and facilities, but the sensible response to that is to increase both to meet the demand.

One way not to go about this is the way chosen by the Association of American Physicians and Surgeons, which has urged its members not to co-operate with the federal program of medical care for the aged. Technically, this group is within its rights; the law does not force compliance. But the AAPS is on shaky moral and professional grounds — as most doctors, we believe, would agree. — *Terre Haute Tribune,* Aug. 19, 1965. ◄

The Journal of the INDIANA STATE MEDICAL ASSOCIATION
Supervised by THE COUNCIL
Volume 58 — November 1965 — Number 11

# An Unusual Foreign Body in the Esophagus

ALDO C. SIRUGO, M.D.*
La Porte
J. R. MATTHEW, M.D.†
Westville

ATTEMPTED suicide is a constant problem in a state mental institution in spite of all precautions of the staff to prevent its occurrence. The commonest form is that of ingestion of various substances or articles.

The wish to die in the severely regressed patient is a constant threat; the avoidance of such incidents and the treatment of emergencies when they do occur places the staff on their mettle constantly. It is essential that an endoscopist be available at all times on the consulting staff of large mental hospitals to treat such emergencies.

During the past year, a severely regressed patient succumbed in the dining room when a large portion of meat became lodged at the bifurcation of the trachea. Shortly after this, an article by Haugen entitled "Cafe Coronary"[1] describing a similar incident appeared in *JAMA*.

## Case Report

A 54-year-old white male was committed to Beatty Memorial Hospital on July 6, 1954 and diagnosed as schizophrenic reaction, chronic undifferentiated type (with marked paranoia and depressive features).

This patient was originally sentenced to the Indiana State Hospital for the Criminally Insane at Michigan City after being convicted of arson. He had a history of having attempted suicide 20 or more times at the state prison.

The patient became extremely depressed periodically, possibly on the basis of auditory hallucinations. His last attempt at suicide was by swallowing a sponge. Prior to that he had attempted to swallow a dessert spoon. The patient had received a number of electro-convulsive treatments with little effect. He was placed on Mellaril and Trilafon as tranquilizing agents.

On March 10, 1964 he swallowed a large tablespoon. Considerable blood was vomited and x-rays showed the tablespoon in the cervical esophagus (Figure 1). The spoon lay in an almost anterior posterior position with the handle in the hypopharynx. The patient showed no evidence of obstruction in the upper airways.

Under general endotracheal anesthesia, the hypopharynx was visualized with a Jackson adult laryngoscope. The handle of the spoon was grasped with a laryngeal forceps and was removed with considerable difficulty. Only with a large dose of Anectine was enough relaxation of the cricopharyngeus obtained to permit the passage of the large part of the spoon. The patient had an uneventful postoperative course.

## Discussion

In 1952, P. H. Holding and K. C. Johnson[2] reported on 2,042 consecutive cases of foreign bodies removed from the air and food passages. They found that while patients of any age may swallow or aspirate

*1200 Michigan Ave., LaPorte.
†Beatty Memorial Hospital, Westville.

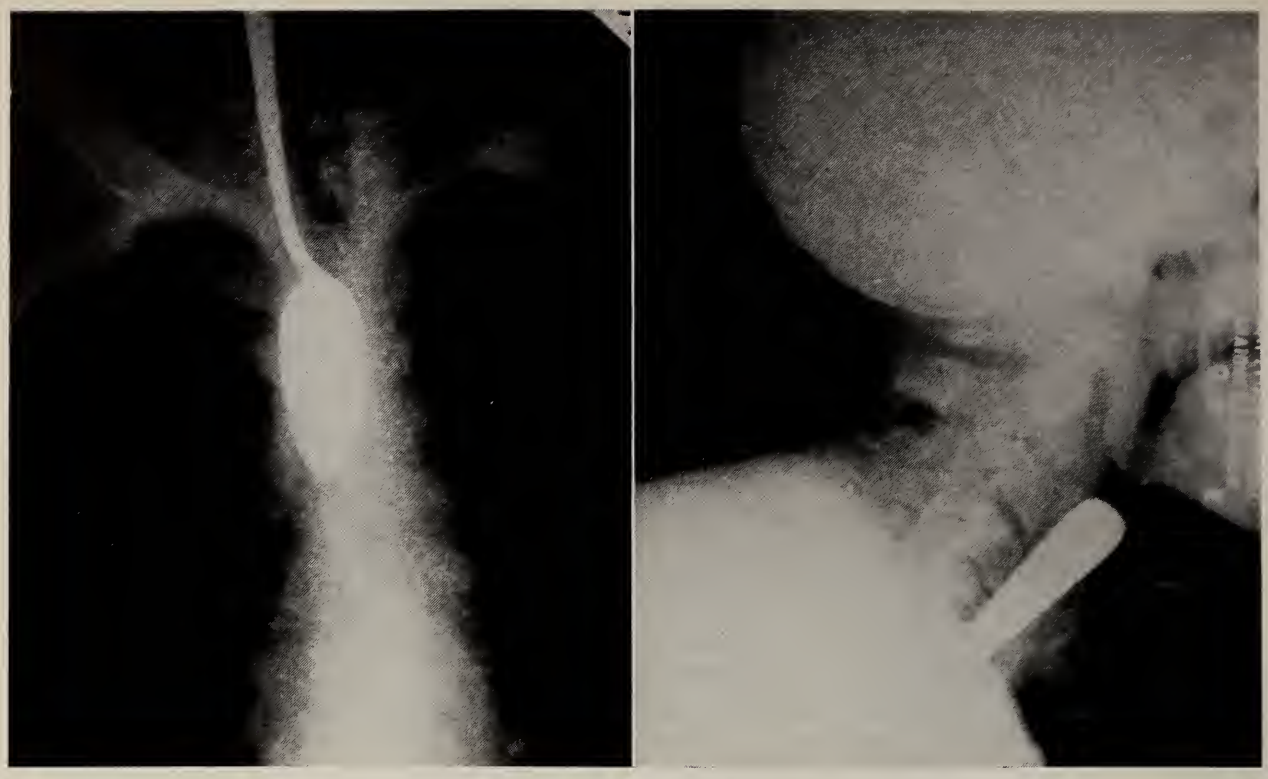


**FIGURE 1 (A and B)**

**X-RAYS show the tablespoon in the cervical esophagus (A). The spoon lay in an almost anterior posterior position with the handle in the hypopharynx (B).**

a foreign body, certain objects are found most frequently in specific age groups. Fowl and meat were frequently found in the adult group. Patients with a sub-normal mentality swallowed a variety of objects.

Symptoms of ingestion of a foreign body can usually be divided in three stages. The initial stage consists of violent paroxysms of coughing and gagging. The patient has difficulty and pain on swallowing. This is generally followed by a symptomless interval so designated because the foreign body becomes fixed and irritating symptoms temporarily subside. This interval is followed by the third stage of complications in which obstruction and tracheal compression occur.

Pathological changes due to esophageal foreign bodies are associated with obstruction, stenosis, erosion, ulceration or perforation of the esophagus. Severe complications such as esophageal perforations and mediastinitis are not uncommon. To establish a diagnosis one must carefully evaluate the history, the symptoms and physical and roentgen studies and then confirm or deny the diagnosis by endoscopic examination. Treatment consists of removal under conditions which will insure safety and minimal trauma to the patient.

REFERENCES

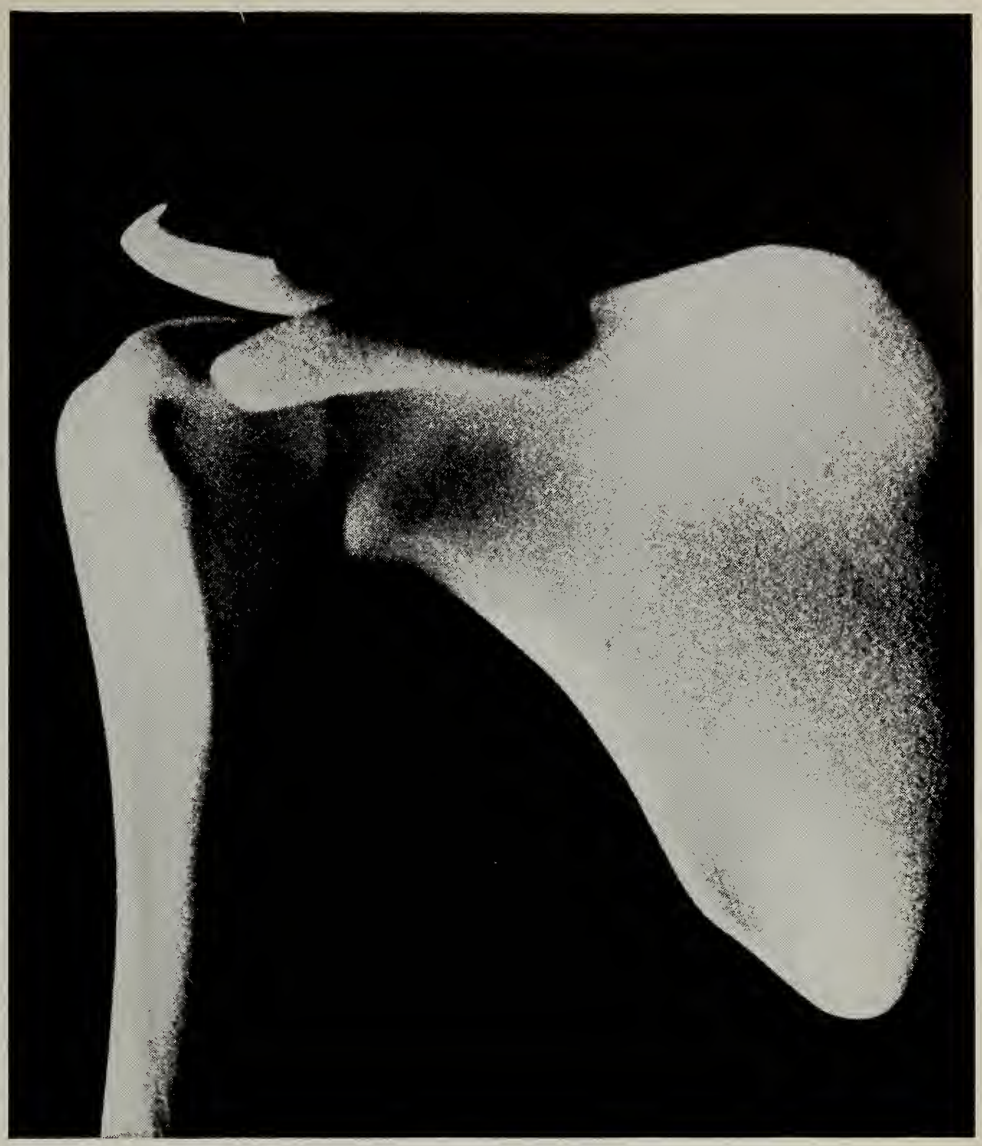
1. Haugen, R. K.: "Cafe Coronary," *JAMA* 186:142, October 12, 1963.
2. Holinger, Paul H., Johnston, Kenneth C.: "Foreign Body in the Air and Food Passages" *Pediat. Clinics of N. Amer.*, Vol. 1, No. 4, Nov., 1954. ◄

# Butazolidin® alka

Each capsule contains:

| | |
|---|---|
| Butazolidin, brand of phenylbutazone | 100 mg. |
| dried aluminum, hydroxide gel | 100 mg. |
| magnesium trisilicate | 150 mg. |
| homatropine methylbromide | 1.25 mg. |

# in painful shoulder



# Geigy

**Therapeutic Effects**
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

**Contraindications**
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

**Precautions**
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

**Warning**
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

**Adverse Reactions**
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

**Average Dosage**
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

**Note:** The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

**Also available:**
**Butazolidin®**
brand of phenylbutazone
Tablets of 100 mg.

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Ardsley, New York

BU 4010P

Case Report and
Review of the Literature

# Diabetes in Pregnancy

ROBERT F. JACKSON, A.B.*
*Indianapolis*

THE PATIENT, a 17-year-old white female, was first seen in the Coleman Hospital prenatal clinic on March 23, 1964. She was a para I, gravida II in her 26th week of gestation. There had been no problems with her pregnancy before this time.

Her past history was not remarkable. Menarche occurred at age 11; her menstrual periods were regular with 28-day intervals, and four days of flow.

Her one previous pregnancy had terminated with a normal vaginal delivery of a full-term, eight pound, nine ounce female. The infant was in good condition at birth and was healthy at the present time.

The patient had been told during her first pregnancy that she "had diabetic tendencies" but there were no complications at that time. Her mother had diabetes mellitus and hypertension; the remaining family history was unremarkable.

### Physical Examination

The patient was well-developed, well nourished and well oriented.

Blood pressure was 120/80 in the right arm recumbant; pulse rate was 84 and regular; respiration 22 and regular.

The only positive finding was a grade I/IV systolic ejection murmur heard best at the apex.

The pelvic examination revealed an adequate pelvis of the gynecoid type; the vaginal walls were normal. The cervix was congested with a gravid os. The adnexa were non-palpable.

Her prenatal course showed a weight gain of 10½ pounds. A glucose tolerance test was administered at the 27th week of gestation. Results were:

Fasting — 95 mg. %
One hour — 195 mg. %
Two hour — 182 mg. %
Three hour — 148 mg. %

At the 30th week of gestation, she was placed on a 3 gm. sodium 140/80/90 diabetic diet. Two hour postprandial blood sugars were drawn at 27, 32 and 37 weeks of gestation. All were indicative of latent diabetes. It was decided to admit her to the hospital for induction of labor in her 37th week of gestation. She was admitted June 25, 1964.

The only positive finding on admission was the grade I/IV systolic ejection murmur mentioned previously.

The membranes were ruptured at 1:00 p.m. At 3:25 p.m., five units of pitocin in 500 cc. of five percent dextrose in water were started intravenously at five drops per minute. The first stage of labor lasted six hours and 15 minutes. The second stage lasted 11 minutes and the third stage lasted eight minutes. Total elapsed time in labor was six hours and 34 minutes.

The delivery was of normal vaginal vertex type which yielded a six pound, nine ounce (2,980 gram) female. The only complication was a first degree perineal laceration which was repaired. Both mother and infant left the delivery room in good condition.

The postpartum course in the hospital was uneventful and the patient remained afebrile until discharged on the third postpartum day.

### Discussion

One of the most serious and challenging problems which come to the office of the obstetrician is the diabetic obstetric case. Prior to the production of insulin in 1921, this type of patient was a rare occurrence as the two conditions were considered noncompatible.

*Mr. Jackson is a senior medical student at the Indiana University School of Medicine.

"When the diabetic woman did occasionally become pregnant, approximately 25% of the mothers and 50% of the infants died."[1] However, since the advent of insulin therapy and with the complete cooperation of the obstetrician, internist, dietician and pediatrician, the prognosis for the diabetic mother and her infant today is very good. Kyle says "The risk of pregnancy to the diabetic mother has declined remarkably since the use of more adequate insulin therapy and improved obstetrical management of toxemia and labor."[2]

It should be noted, however, that though good management yields a good prognosis, the unmanaged obstetrical patient who manifests diabetic tendencies or the uncontrolled diabetic who becomes pregnant has a grave prognosis.

### Etiology

Many authors consider pregnancy a diabetogenic event due to the hormonal alteration during pregnancy.[2,3] DeCosta, however, states that the term diabetogenic is a poor choice of words. He says, "Pregnancy may put sufficient strain on the genetically defective beta cells so that altered metabolism becomes apparent, but pregnancy does not cause diabetes."[4] His view is supported by Kyle who says, "Whether or not abnormalities of carbohydrate tolerance appear probably depends on the functional state of the islets of Langerhans prior to conception. Normal islets meet the demands but functionally inadequate islets cannot and hyperglycemia supervenes."[2] Whether pregnancy is diabetogenic or not, it often provides the first indication of altered carbohydrate metabolism.

There are various viewpoints as to the cause for this excess strain. Young believes it is due to the increased production of growth hormone which increases insulin production. When the pancreas becomes unable to increase the amount of insulin, diabetes becomes apparent.[2] Pearson agrees with this concept as he says, "Growth hormone is diabetogenic in many normal animals and also in man."[5] Others believe it is the hormonal influence of the placenta, ovaries, etc.

According to Kyle, the term pre-diabetic should probably be discarded since it can only be used in retrospect. He feels this term should be reserved for the period of time between conception and the appearance of an abnormal carbohydrate metabolism and that the term latent diabetic would be more applicable.[2]

Though the academic problem of the diabetogenicity of pregnancy is interesting, the main purpose of this article is to discuss the clinical aspect of the problem.

### Diagnosis

Essential preliminaries to the rational treatment of diabetes are diagnosis and an accurate appraisal of the degree of severity. Due to the extreme seriousness of this problem, a number of clinicians including Carrington advocate two hour postprandial blood suger tests be administered routinely to all prenatal patients.[3]

According to Dr. Molnar of the Mayo Clinic, there are two factors which aid the obstetrician in uncovering latent diabetes: 1.) diabetogenic effect of pregnancy may bring an otherwise latent glucose tolerance impairment to light because of lowered renal threshold, and 2.) there is the likelihood that the patient will seek medical attention during the pregnancy.[6]

Whether one wants to subscribe to Dr. Carrington's view on two hour postprandials would probably be decided by factors such as the socio-economic level of the patients, the laboratory facilities, the patient load, etc. There are, however, certain individuals who present clinical clues of impending diabetes. The most important and significant of these are: 1.) a family history of diabetes; 2.) a history of increasingly large, stillbirths or habitual abortions; and 3.) glycosuria.[6] A patient with any of the above conditions should be watched closely and should have further blood sugar tests. Danforth and Boronow state that a glucose tolerance test is clearly indicated where there is a history of a baby weighing nine pounds or more.[7]

When does one consider a blood sugar test abnormal? There is a tremendous variance in opinion on this score. The Mayo Clinic considers the following figures as indicative of diabetes: A concentration

of 150 mg./100 ml. at the end of one hour and 110 or more at the end of two hours.[6] However, most authors will agree that a two hour postprandial of higher than 120 mg./100 ml. is suggestive.

Treatment of the diabetic patient as well as a better evaluation of her prognosis is facilitated by classifying the severity of her disease. The following is White's classification as given by Kyle[2]:

Class A. — Abnormal glucose tolerance test only. No insulin required. No fasting hyperglycemia.

Class B. — Onset of diabetes after age 20. Duration of diabetes 0-9 years. No detectable vascular changes.

Class C. — Onset of diabetes between the ages of 10-29 or a duration of diabetes 10-19 years. No detectable vascular changes.

Class D. — Onset of diabetes before age 10. Duration of diabetes more than 20 years. Calcification in legs, retinopathy or both.

Class E. — Changes in Class D and calcification of the pelvic vessels.

Class F. — Chronic albuminuria, nephropathy.

Using a classification such as the one above or another designed by the practitioner himself will help in deciding on the degree of control and management of the patient.

The problem of diabetes alone is sufficient reason for a thorough history and physical examination on all prenatal patients. The lives of the pregnant diabetic patient and her infant may well depend on this diagnosis. Points in the history and physical examination which should warn the practitioner of the possibility of diabetes are: 1.) A history of increasingly large babies; 2.) a family history of diabetes; 3.) glycosuria; 4.) a number of unexplained neonatal and intrauterine deaths; 5.) a history of toxemia and excessive weight gain during previous pregnancies; and 6.) a patient exhibiting hydramnios. Any of the above signs require more study and diagnostic testing to rule out diabetes.

**Management**

The management of the pregnant diabetic patient under optimal conditions is no longer a one-man job, but requires the combined efforts of the obstetrician, the internist, the dietician, the pediatrician and the patient herself. However, in many areas this responsibility must still be assumed by one man. As Kyle states, "Only good obstetrical supervision and cooperation of the patient will keep deaths due to toxemia and obstetrical accidents to a minimum."[2]

Crenshaw states, "Chemical control of the diabetes must be the chief concern with more careful management from the thirty-second to the thirty-eighth week of pregnancy."[8] His view is supported by Molnar who says, "In the care of the pregnant diabetic, proper management of the diabetic state is the primary consideration. The management of her diabetes mellitus from day to day through pregnancy, delivery and the postpartum period is a major concern of the obstetrician."[6]

Exactly what is good management? Molnar states that "perfect" or "excellent" control of diabetes is a state in which the diabetic organism is rendered temporarily "non-diabetic" through therapy.[6] He goes on to say, in light of the fact that this is almost impossible, a satisfactory compromise is reached when the patient can maintain a satisfactory weight, with a normal range fasting and two to three hour postprandial glucose concentrations in venous blood, absence of detectable glucose in the urine, and absence of ketosis and insulin reactions.[6] The methods used to obtain "perfect" or "excellent" control are diet, and if needed, diet plus insulin and close surveillance. There must be numerous blood sugar tests administered—either glucose tolerance or two hour postprandials to assay the effectiveness of the treatment.

Since the pregnant diabetic patient requires more constant supervision than does the non-diabetic, the frequency of her visits naturally need to be increased. Danforth and Boronow recommend that the patient should be seen every two weeks during the first six months and every ten days during the seventh and eighth month. During the last month, she should be seen every week.

If both an obstetrician and internist are working on the case, the visits can be divided.[7] Kyle indicates that the pregnant diabetic patient should be seen every two weeks during the first half of her pregnancy and every week thereafter.[2] As was stated previously, the frequency of visits can be partially regulated by the severity of the diabetes. At any rate, the visits must be more frequent for the diabetic than the non-diabetic patient.

According to Molnar, dietary measures are the basis of therapy for the diabetic patient because about half of treated diabetic patients require no additional measures.[6] The diet for the diabetic patient should permit a 15 to 20 pound weight gain. The caloric intake should range between 1,200 and 3,000 calories per day, calculated on the basis of ideal weight and depending on the obesity of the patient. Optimal protein is 1.5 to 2.0 grams per kilogram per day, carbohydrate intake should be at least 150 but not more than 250 grams per day, and fat should supply the remaining calories.[2]

The insulin requirement must be appraised and met as it occurs. It should be noted that insulin requirements often increase in pregnancy, especially during the last months and this fact must be appreciated by both physician and patient.

Lastly, but by far one of the most important facets of therapy is a well-informed patient. "When the diagnosis of diabetes is made in the pregnant patient or diagnosis of pregnancy in the diabetic patient, it is the responsibility of the obstetrician to outline the essential need for full cooperation and to illustrate the hazards that are in store."[7] It is the well-informed patient who knows of the problems which can arise and has at least some understanding of how to cope with them. That is of greatest assistance to the obstetrician. The description of these problems should be lucid and vivid enough that it will provoke complete cooperation.

There are a number of complications which have increased incidence in the pregnant diabetic such as toxemia, ketoacidosis, polyhydramnios, infection and hyperemesis. These must be managed if they arise and will be discussed later under "Complications."

Crenshaw states that "If signs of toxemia, ketoacidosis, polyhydramnios or infection appear, the pregnant diabetic should be hospitalized." He further advocates hospitalizing all pregnant diabetics regardless of their condition at the thirty-sixth week of gestation.[8]

The prenatal care of the diabetic is an important, complicated and challenging experience. It must be accomplished using any and/or all of the medical resources available.

## Complications

There are a number of complications which aggravate diabetic control. Due to the jeopardy in which the infant is placed by acidosis, these must be mentioned. They are infection, toxemia and hydramnios.

As is stated by Danforth and Boronow, "Infections are a serious hazard to any diabetic, but during pregnancy much more is at stake than the annoyance of difficulty in metabolic control." They further advocate the hospitalization of all but the most trivial of infections.[7] They are supported in this view by Crenshaw.[8]

Treatment of the infection with antibiotic therapy should be based on culture and sensitivity tests. However Boronow and Danforth believe that in the presence of fever, it is permissible to begin antibiotic therapy before the organism has been identified.[7] It seems that in light of the danger placed on both mother and infant, good treatment should consist of 1.) immediate culture and sensitivity tests to select the causal agent; 2.) instituting antibiotic therapy immediately; 3.) and then changing therapy if, after identification, another agent is preferable. No matter what the agent of choice is, it should be administered in "full dose" quantities. We cannot set the stage for resistant strains.[7]

Any infection should be carefully followed, treated, and an internist, if possible, should be consulted.

Toxemia is another complication which has a higher incidence in the pregnant diabetic. Diabetes is one of the four conditions

commonly considered as predisposing to toxemia.[7]

DeAlvarez states, "If one wishes to study toxemia before it becomes clinically manifest, one cannot do better than to observe the pregnant diabetic who is more likely to develop this complication than any other pregnant woman."[9] I will not attempt to delve into the factors present in the diabetic which predispose to toxemia but will rather confine myself to diagnosis of this complication and its treatment.

Since toxemia of pregnancy is an anticipated complication, efforts should be made to prevent its occurrence.[9] Diabetic ketosis and coma, the most feared complication of diabetes, may appear as the first sign of the disease.[9] Once coma ensues, it is important that it be differentiated from the coma of eclampsia and pre-eclampsia. The differential is quite easy since in pre-eclampsia and eclampsia, the blood sugar level and blood ketones are normal and glycosuria is absent.

DeAlvarez states that the treatment of toxemia is mostly prophylactic and advocates the following:[9]

1. Dietary management and assessment by the laboratory of its success.
2. Restriction of the sodium ion throughout the pregnancy is a must.
3. Repeated blood sugar fasting and two hour postprandials should be done at every visit. He says weekly.
4. The nausea of early pregnancy should be vigorously combated and if vomiting occurs, fluids, calories and electrolytes should be replaced.
5. Early delivery is a must. (This point will be discussed later.)
6. If edema occurs one may use a thiazide diuretic, but the patient should be seen twice weekly and diuretic therapy should be preceded by base line electrolyte studies.

Hydramnios is the last of the complications which will be discussed here. This complication occurs in from 10-50% of pregnant diabetics. However, according to Boronow and Danforth, no adequate solution to its prevention or management has been found. Diuretics and salt restriction seem to be of dubious benefit. It should be noted, however, that this complication is often the key to a difficult period of diabetic management. Therefore, when hydramnios occurs, very close surveillance must be initiated.

### Delivery

A number of authors agree that the pregnant diabetic should not be allowed to proceed to term and no diabetic, either latent or frank, should be allowed to go beyond term.[10,11] Kyle states that "When the pregnant diabetic is allowed to proceed to term, there is considerable risk of in utero loss during the last four weeks of pregnancy."[2] According to Patton, the optimal time for delivery is when the fetal weight is an estimated seven pounds.[12]

Kyle has drawn the following conclusions concerning when the pregnancy should be terminated: 1.) fetal survival is improved by early termination of the diabetic pregnancy; 2.) neonatal loss prior to the 35th week is so great as to preclude interruption before the 36th week in the presence of a severe maternal or fetal threat; 3.) intrauterine death after the 38th week is so high that delivery should be effected prior to this time except perhaps in the uncomplicated pregnancy in which insulin is not required; and 4.) maximum fetal survival appears to be achieved when a gestational age of 252-266 days coincides with a fetal weight of 3,500 to 3,950 grams.[2]

There may be some help forthcoming from estriol studies for decreasing intrauterine deaths and also on the optimal time for delivery. Several authors have demonstrated that a persistent fall in estriol excretion in the pregnant diabetic indicates impending fetal death.[2]

According to McElin, there are two major decisions which the obstetrician must make —when to deliver and by what route.[13]

There are many viewpoints as to which type of delivery is best. Patton believes that the infant fares better if delivered vaginally; however, he goes on to say that the timing of the delivery is more important than the method by which one chooses to deliver the infant.[12]

McElin,[13] states that the indications for

Caesarean section are:

1. Absence of safe requisites for induction of labor when delivery is deemed advisable. This naturally pre-selects and assigns most primigravidas for abdominal delivery.
2. Anticipation of a difficult delivery as, for example, when pelvic capacity is questionable or the infant is of excessive size.
3. Presence of poor obstetric history, including prior fetal loss, previous traumatic vaginal delivery and prior Caesarean section.
4. Prolongation of active labor (over 12 hours) with delivery not imminent.
5. Rupture of membranes for 24 hours in instances in which effective contractions may not be induced.
6. Breech presentations in all primigravida patients and almost all multigravida patients.

The indications for vaginal delivery are utilized in the following situations, according to McElin[13]:

1. For the patient who goes into spontaneous labor, whose infant is thought to weigh less than nine pounds and whose pelvis is judged to be adequate.
2. For the patient whose fetus is known to have a major congenital defect verified by x-ray.
3. The patient with a dead fetus in utero.
4. For the primigravida or multigravida under perfect diabetic control with an infant of adequate size, without any additional medical or obstetrical complications, in whom all of the usual criteria for induction of labor are present 21-28 days from term. Such patients may be submitted to an induction of labor.

White advocates Caesarean section if after eight hours of labor, the patient has not progressed satisfactorily to indicate that delivery is shortly forthcoming.[13]

McElin has reviewed the mortality records of Evanston Hospital and he does not believe any of the deaths were directly related to the mode of delivery.[13]

Before closing the topic of delivery, we must discuss anesthesia. According to Hartridge, regardless of the mode of delivery, regional anesthesia is best.[15] Pudendal block seems to be a good method for vaginal delivery and is advocated by many authors. Most authors agree regional anesthesia is best, even for Caesarean section.

The important factors in consideration of delivery of the pregnant diabetic seem to be pre-term delivery and either vaginal delivery possibly with induction of labor or Caesarean section. Using the criteria stated above in making a choice of time and mode should improve the prognosis of both mother and infant.

### Fetal Survival

Many theories have been formulated as to the cause of fetal mortality in the pregnant diabetic. Many believe the placenta to be responsible. However, Sir John Peel does not believe this is true.[14] Both Burnstein and Heijkenzold have found placental changes in the diabetic placenta, however.[2] No matter what the cause of fetal death, there is a greater mortality rate among children of diabetic mothers.

How do we treat these infants? Gellis states "Treatment should be aimed at the respiration distress syndrome. If distress is noted, oxygen may be required and should be held at a concentration below 35-40%.[16]

There are other factors which may be present in the infants of diabetic mothers. They may have birth injury due to their large size and the inadequacy of the mother's pelvis. The infants of diabetic mothers have a higher incidence of congenital malformations. There is conflicting evidence on the effect of hypoglycemia seen in most infants of diabetic mothers, and it seems more work needs to be done in this area.

According to Dr. Stander, "The infant of the diabetic mother more often needs gastric lavage than the infant of the non-diabetic mother."[17]

### Postpartum Management

The postpartum care of the diabetic is naturally governed by the degree of her diabetes as well as her progression through any complications of labor and delivery.

According to Eastman, "The diabetes is more difficult to control during the puerperium than at any other time. The wide and sudden fluctuations which the blood sugar sometimes undergoes during this period are presumably the result of a num-

ber of factors: endocrine and metabolic changes associated with the reconversion of bodily mechanisms to their non-pregnant state, slight degrees of puerperal infections, conversion of certain amounts of blood glucose into mammary lactose, and possibly the withdrawal of the fetal pancreas."[1]

However, he goes on to say that though these changes are seen during the first week postpartum, the diabetes normally returns to its pre-pregnancy state.[1] He states that there is no evidence that pregnancy permanently aggravates diabetes.[1]

The obstetrician or general practitioner should re-evaluate the diabetic state at the time of the six weeks check-up. No study has been completed on the number of latent diabetics that go on to become clinical diabetics in later life. Many authors do, however, believe that a good portion of these women do develop diabetes at a later date.

## Summary

Though there has been a tremendous decline in both maternal and fetal mortality associated with diabetes in pregnancy, the practitioner who is caring for the obstetrical patient needs constantly to be watching for the diabetic. Once he has made the diagnosis, he must follow rigid prenatal care and terminate pregnancy by effecting delivery at the optimal time. In the future, estriol studies may help the physician decide when to deliver. This may help tremendously also in decreasing intrauterine deaths; however, more study must be done in this area. The pregnant diabetic is truly an interesting problem and an academic challenge to the physician working in the field of obstetrics.

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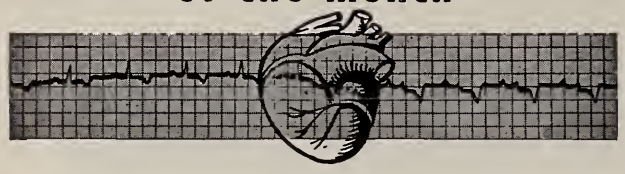
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# Electrocardiogram
## of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *EKG in Hypercalcemia*

*CHARLES FISCH, M.D.*
*Indianapolis*

ELEVATED serum calcium rarely produces significant electrocardiogram changes other than shortening of the Q-T interval. Occasional prolongation of the P-R interval and inversion of the T wave has been described.

The tracing in Figure 1 obtained in a patient with hyperparathyroidism showed all the characteristic EKG features of hypercalcemia. EKG obtained on 2-14-62 when the calcium level was 16 mg. % demonstrates a P-R interval of 0.20 seconds, Q-T of 0.28 seconds and an inverted T wave in leads I, II, III, AVF and V2-V6. The inversion of the T wave in this case of hypercalcemia attests to the nonspecificity of T wave inversion.

When the calcium level dropped to 9.0 mg. %, the P-R shortened to 0.16 seconds, the T wave became upright, but the Q-T interval remained at 0.28-0.30 with absence of an isoelectric S-T segment suggesting that this particular feature of hypercalcemia had perhaps not yet reverted to normal.

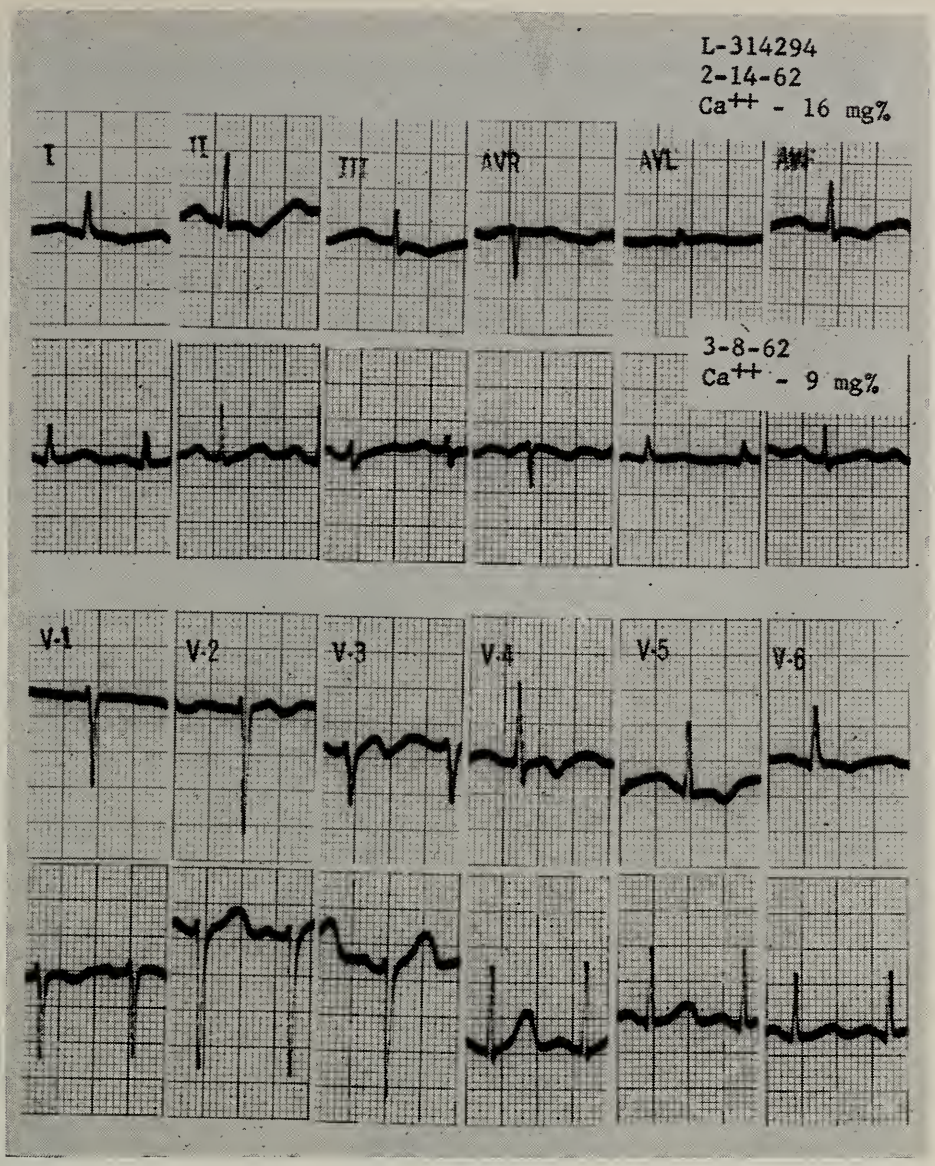



**FIGURE 1**

**THIS figure demonstrates the EKG changes during hypercalcemia (2-14-62) and reversion of the P-R interval and T wave to normal with drop in serum calcium (3-8-62).**

*"...it is extremely difficult and sometimes impossible to differentiate between 'pure depression' and anxiety and it is questionable whether depression without a certain degree of anxiety really exists."*

Lehmann, H. E., Canad. Psychiat. Assn. J. *4(S)*: 1-12, 1959



# An antidepressant designed for the clinical realities of office practice

**As many physicians have reported, the large majority of neurotic depressed patients suffer from both depression and anxiety. It may be difficult to decide whether these patients are primarily depressed or primarily anxious. And yet drug treatment of only the symptom which seems more prominent may exacerbate the untreated element of the depression complex.**

**Consequently, it would seem that therapy specifically aimed at both the depression and associated anxiety and tension should increase success in treatment.**

**This is one of the important reasons why 'Deprol' has proved particularly helpful. For 'Deprol' acts rapidly both to lift the mood and to relieve the associated anxiety, tension and insomnia.**

**And side effects, at recommended dosage, have been infrequent and generally readily controlled.**

**Indications:** 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

**Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

**Precautions:** *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

*Benactyzine hydrochloride*—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

*Meprobamate*—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Cavernous Sinus Fistula of the Carotid Artery*

ERICH K. LANG, M.D.†
*Indianapolis*

SOME six months ago, a 52-year-old white female was admitted to the hospital with complaints of intractable headaches. Neurologic examination at that time was unremarkable. The presence of a pulsatile exopthalmus of the left eye was suggested. Cranial nerves, and in particular the third, fourth, sixth and the first division of the fifth nerve showed no evidence of abnormality.

A pneumoencephalogram showed the ventricles to be in normal position and of normal size. The basilar cisterns, as far as demonstrated, were likewise unremarkable. An arteriogram showed dye collection in what appeared to be an aneurysm, arising from the intercavernous portion of the left carotid artery. The dye collected in this particular aneurysmal sac, however, there was no filling of the cavernous sinus and the presence of a cavernous sinus fistula could not be established.

A gradual ligation of the internal carotid artery with a Silverstone clamp was suggested to the patient but she declined to submit to this operative procedure.

Six months later, the patient again sought medical aid. At this admission, a very marked, severely pulsatile exopthalmus of the left eye was noted. Neurologic examination revealed positive cranial nerve findings of the fourth, sixth and the first division of the fifth nerve.

A restudy by arteriogram showed dense opacification of the cavernous sinus on the first phase film (Figure I). This established the diagnosis of a ruptured aneurysm of the internal carotid artery, with formation of an arteriovenous fistula between the internal carotid artery and the cavernous sinus. The fistula communicated the left internal carotid artery and the cavernous sinus. An injection into the right carotid system revealed cross-filling over the anterior communicator branches, as well as the posterior communicator branches, and reopacification of the cavernous sinus. The shunt from the right carotid system to the left side and into the cavernous sinus was felt to be hemodynamically significant.

A two-stage operative procedure was suggested for treatment of this condition. The first stage consisted of application of a Silverstone clamp to the internal carotid artery on the left side. Gradual decrease of flow into the internal carotid system was accomplished by progressive compression of the lumen by the clamp.

The second stage proposed to trap the arteriovenous malformation and fistula between the Silverstone clamp and the silver clip, occluding the internal carotid artery above the intercavernous segment. Thus, the reversed cross circulation from the right carotid system into the arteriovenous fistula would be occluded.

* Supported by a grant of the American Cancer Society, Indiana Division.

†Department of Radiology, Methodist Hospital, Indianapolis.

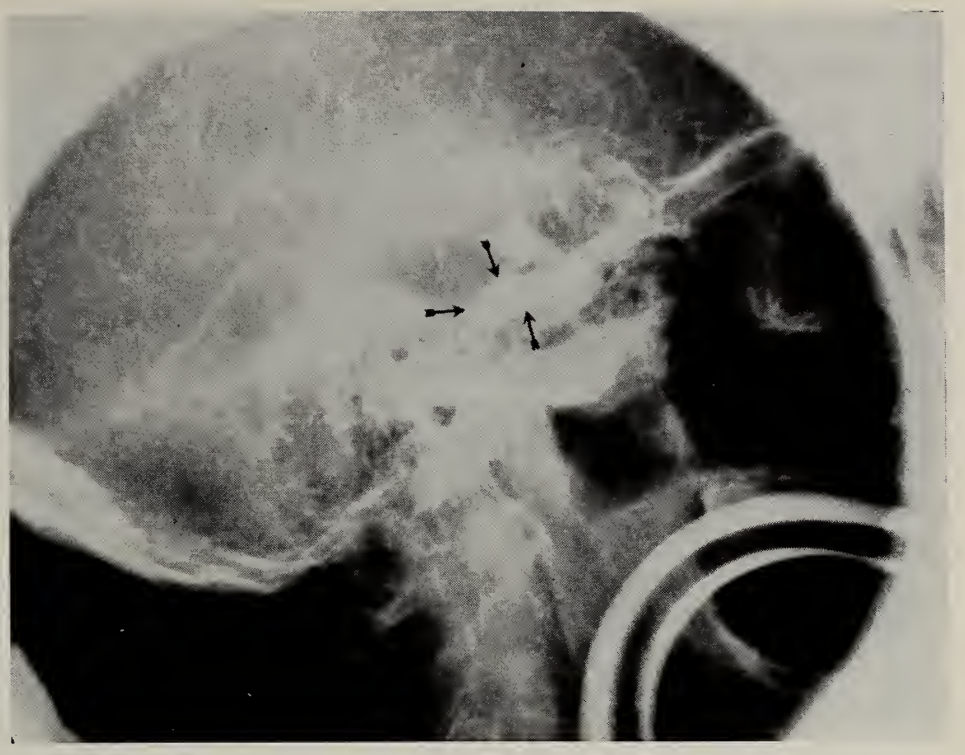


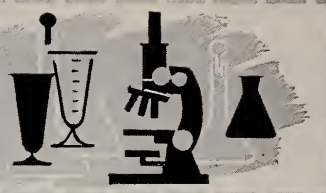
FIGURE 1
NOTE immediate opacification of the cavernous sinus on the arterial phase film of a left carotid arteriogram. The siphon segment of the carotid artery and the cavernous sinus show equal density. This establishes the diagnosis of a cavernous sinus fistula of the carotid artery.

## Comment

Arteriovenous fistulas between the internal carotid artery and the cavernous sinus are not uncommon complications of intracranial aneurysms. The fistulas are formed by the rupture of an aneurysm of the internal carotid artery, within the intercavernous segment of the carotid. The manifestations are fairly consistent, and include pulsatile exopthalmus and varying neurologic manifestations of cranial nerves, particularly of the third, fourth, sixth and first division of the fifth cranial nerve.

The treatment of choice is double ligation of the involved carotid artery above and below the aneurysm to prevent retrograde flow from the contralateral side via the circle of Willis and thus dissipation of intracranial blood flow. The results are usually gratifying and in most cases, an adequate collateral pathway via the circle of Willis insures blood supply to the hemisphere whose carotid artery has been ligated. ◄

Path-finder
PUBLISHED UNDER THE AUSPICES OF THE INDIANA ASSOCIATION OF PATHOLOGISTS



**This series is intended to emphasize the importance of judicious selection and proper interpretation of newer laboratory procedures as applied to differential diagnosis of various diseases. It is edited by Leon L. Blum, M.D., Terre Haute.**

# *Differential Diagnosis of the Month:*

# *HYPOADRENALISM*

*WEI-PING LOH, M.D.**
*Gary*

| | |
|---|---|
| *Clinical Data:* | A 40-year-old man was admitted because of poor appetite, loss of weight, weakness, tiredness, irritability, depression and intolerance to extremes of temperature of about a year's duration. All of these symptoms began insidiously and had increased gradually in severity throughout the year. |
| *Physical Examination:* | The patient appeared to be chronically ill, thin and weak. Brownish discoloration was noticed on the knees, elbows, knuckles and skin folds. Skin and mucous membranes appeared to be dehydrated. Blood pressure was 90/70; pulse: 80/min. and regular; heart small on percussion. Other findings were unremarkable. |
| *Laboratory Data:* | Mild normochromic and normocytic anemia. WBC, differential count and urinary findings were within normal limits.<br>Serum sodium: 110 mEq/L (normal: 132-148), potassium: 5.8 mEq/L (normal: 3.5-5.5), chlorides: 86 mEq/L (normal: 98-108).<br>Urinary 17-ketosteroids: 3 mg./24 hrs. (normal: 8-20).<br>Urinary 17-OH-corticosteroids: 1.5 mg./24 hrs. (normal: 3-10).<br>Oral glucose tolerance: relatively flat curve.<br>X-ray studies confirmed the small heart and revealed calcification in both adrenal areas. |

*Chief Pathologist, Methodist Hospital of Gary, Inc.; Asst. Professor of Pathology, Chicago Medical School.

| | |
|---|---|
| *Consultation Note:* | A pathologist was consulted; he suspected hypoadrenalism. In order to differentiate primary hypoadrenalism (due to disease of the adrenal) from secondary hypoadrenalism (due to disease of the pituitary) he recommended applying ACTH and SU-4885 (Methopyrapone) in the differential tests. The test results pointed to primary hypoadrenalism and the condition was diagnosed as Addison's disease. |
| *Interpretation:* | The history, physical findings and laboratory findings are typical of hypoadrenalism. For proper therapy, it is important to differentiate primary from secondary hypoadrenalism. To attain this goal one often applies ACTH and sometimes SU-4885 in the differential tests. ACTH is used to stimulate the adrenal cortex. SU-4885 acts through its inhibition on the hydroxylation at the C-11 of the steroid molecule, thus causing a decrease in cortisol level. Their value is illustrated in the following table. |

## HYPOADRENALISM

| Test | Baseline | After ACTH* | | After SU-4885** | | Other Organ Pathology |
|---|---|---|---|---|---|---|
| | | Primary | Secondary | Primary | Secondary | |
| Eosinophil count | ↑ | NR | → or ↓ | NR | NR | → or ↓ |
| 17-ketosteroids (urine) | ↓↓↓ | NR | → or ↑ | NR | NR | → or ↑ |
| 17-OH-corticosteroids (urine) | ↓↓ | NR | → or ↑ | NR | NR | → or ↑ |
| Cortisol (plasma) | ↓↓ | NR | → or ↑ | NR | NR | ↓↓↓ |

↑ : increase → : normal ↓ : decrease

NR: no response or no change from previous level.
The number of arrows indicates the degree of change.
*ACTH: 80 units in gel per day, IM, for three days.
**SU-4885: commercially known as Metopirone (metyrapone CIBA), given in dosage of 30 mg. per Kg. of body weight, as intravenous infusion over a four-hour period.

The increase in urinary 17-OH-corticosteroid excretion following ACTH appears to be the best indication of secondary hypoadrenalism due to disease of the pituitary.

As indicated in the above table, good response following SU-4885 practically rules out basic disease in the adrenal as well as in the pituitary. Under such circumstances, one should look for disease in other organs, such as the thyroid, etc.

The SU-4885 test has limited value in hypoadrenalism (primary or secondary), although some pathologists believe that failure to respond following SU-4885 most likely indicates hypopituitarism or secondary hypoadrenalism.


REFERENCE

Chicago Medical School Clinical Pathology Case Studies: Chemistry No. 11.

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# Indiana Tornado Report

MULTIPLE tornadoes produced widespread areas of injury and property destruction in Indiana on April 11, 1965.

Eleven of the state's 92 counties were heavily affected and five other counties were lightly damaged. One hundred and thirty-eight persons died and 1,369 were injured; 1,204 private residences were destroyed, as well as 1,096 farm buildings and 76 industrial and school buildings. Four hundred and sixty-seven automobiles were destroyed or seriously damaged, as well as 117 trucks and 132 mobile homes and trailers. Property damage exceeded $150 million.

A report and critique of medical service in the disaster has been made by the Indiana Trauma Committee of the American College of Surgeons.

Overall command of rescue operations in a disaster is sometimes inadequate. In this case, the command function at the various scenes of injury was assumed by the county sheriff or by the state police. In every instance it was efficiently executed.

Communication by police radio, "ham" operators and radio news broadcasts was good with the exception that a few news broadcasts inadvertently produced overshifting of medical personnel from one county to another.

First-aid at the scene was occasionally hurried and there was a general tendency to transport the injured too soon and too quickly. More time could have been spent in sorting the severely injured and in preparing them for transportation.

As was the case with the Indianapolis Coliseum disaster, hospitals were not notified as to the number and nature of the casualties.

Emergency room care at the hospitals was satisfactory. In some instances in which the regular power supply was interrupted, stand-by power was not connected immediately. A few emergency rooms did not have an alternate method of sterilizing instruments when electrical power failed.

The number of doctors, nurses and technologists was considered adequate in all cases but, while all personnel functioned well individually, there appeared to be need for more teamwork.

Almost all hospitals reported that everyone worked diligently for about the first 24 hours, but sufficient replacements were not available for relief. Each hospital should have had or should have developed a reserve force to provide coverage during the second 24 hours.

Summary for the operation was: WELL DONE. There are always, however, small segments of any procedure which may be

improved. Recommendations arising from this disaster are that severely injured people be moved as little as possible until their condition improves; that continuity of care be provided, and that practice drills in communication, command function and coordinated team work with actual drills be planned at continual intervals until the next disaster occurs.

*Guest Editorials*

## Latent Diabetes And Pregnancy

THERE is no doubt that sufficient attempts at case finding of latent and manifest diabetes would prevent much human wastage. The physician however, even without case finding is frequently presented with excellent opportunities in nature not merely to detect the manifest diabetic but to find the latent case as well. This occurs in every situation in which burdens on the beta cells of the islands of Langerhans are increased. Corticosteroid therapy increases gluconeogenesis which raises the blood sugar, thereby causing increased demands for insulin. A high carbohydrate diet stimulates the beta cells to secrete more insulin. The growth hormone which rises to three times normal in pregnancy, increases the blood sugar level and with it comes an increased demand on the islet cells for insulin. The combination of these three factors, which occurs in pregnancy, can make a prediabetic into a latent diabetic and a latent into frank diabetes.

Normally, there is no way to diagnose prediabetes except after the fact in retrospect. It is therefore not a clinical diagnosis. Latent diabetes however, becomes manifest during periods of stresses upon the beta cells, as for example, during pregnancy or corticosteroid therapy or rapid weight gain only to return to normal when the puerperium begins, or corticosteroids are withdrawn or following substantial weight loss. During each of these stress periods, diabetes does exist. Between these periods there is no demonstrable diabetes and therefore the diabetes is latent. Stated in another way, latent diabetes implies a period during which previously demonstrable diabetes cannot be demonstrated by the usual diagnostic procedures. Since pregnancy is a diabetogenic event, latent diabetes may become manifest, but if it does not, it can readily be exposed by a variety of tests and a careful study of previous history of the patient which can raise the index of suspicion of diabetes.

Kyle[1] points out that when there is a history of a large baby, stillborn or neonatal loss, one should seek evidence for diabetes. He points out that 77% of women in one series with infants greater than ten pounds later developed overt diabetes. This is confirmed by abnormal glucose tolerance tests in such women. The same is true in cases of stillborn or neonatal loss, in which glucose tolerance tests in future pregnancies will be more often abnormal than in an unselected series. Most women with an abnormal tolerance test appearing during pregnancy will revert to normal carbohydrate tolerance in the puerperium. Nevertheless, this sign also adds to a high index of suspicion because in these patients permanent diabetes often eventually ensues.

The attempt to search out the latent diabetic has led to an increased interest in the borderline abnormalities of glucose tolerance tests. There has been developed the steroid enforced glucose tolerance, the intravenous tolbutamide test and a prednisone glycosuria test.[2] Each of these has been investigated with the hope it might prove more sensitive than the standard oral glucose tolerance test in demonstrating early evidence of impaired beta cell reserve.

As a result of retrospective studies, a possible prediabetic history has gradually come to be recognized. If there is a history of glycosuria during pregnancy, or an unexplained intrauterine and neonatal fetal loss: if there is a history of hydramnios or a very large infant, then one should develop a high index of suspicion and employ glucose tolerance tests as a means of detecting

subclinical diabetes—most likely to be demonstrated during the last trimester of pregnancy.

Should diabetes not be recognized during pregnancy, fetal embryopathy can point a finger of suspicion to diabetes in the mother. Stillborn infants[3] with enlarged islet areas turned out to be of mothers that had overt diabetes or abnormal glucose tolerance curves. This finding is significant also to the surviving offspring of diabetic mothers. Such offspring show a greater hyperglycemia during early neonatal life. The islet hypertrophy may in fact be a forerunner of permanent damage to islet reserve and may lead to a higher incidence of diabetes. Jackson[4] however, believes that if the child survives at all, it recovers completely.

If prediabetes is suspected on the basis of a family history, previous glycosuria or a suspicious obstetrical history, then the carbohydrate tolerance tests may reveal borderline or unequivocal diabetic curves. At this point, there are therapeutic measures which should be instituted such as premature termination of pregnancy, varying doses of insulin even in the absence of hyperglycemia, and strict dietary management designed to prevent excessive weight gain or to achieve a described weight loss. In principle this removes one of the burdens on the islets.

Kyle has repeatedly observed a return to normal carbohydrate tolerance following four to eight weeks of insulin therapy during pregnancy. This of course, serves to eliminate a burden upon the islets. A return to normal carbohydrate tolerance has also been reported by Fajans and Conn[5] in some asymptomatic diabetic patients following a period of tolbutamide therapy. Other means of sparing the islets such as correcting obesity and preventing future obesity must also not be neglected. Kyle reports an obese woman with a frankly abnormal glucose tolerance test who after weight reduction, sustained two pregnancies with no abnormality of any glucose tolerance test.

The increased interest in the relationship between pregnancy and diabetes will inevitably lead to greater numbers of newly discovered diabetics, many of whom will have a demonstrable abnormality of carbohydrate tolerance during pregnancy. These women should offer a unique opportunity for study. We still need to know more about the physiologic sequence of events occurring in the pregnant diabetic. We need more information about hormonal and non-hormonal antagonists of insulin, and about placental degradation of insulin.

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—Louis H. Nahum, M.D., Editor. Reprinted with permission from *Connecticut Medicine* 29:617-18, Sept., 1965.

**(See article on this same topic on pp. 1228-1234 in this issue).**

## Where's All Thy Lustre Now?

THERE are things we must not say. They are whatever is critical of motherhood, patriotism and religion. If we believe they are true, we do not say them. The majority has always laughed at, and has won over the small efficient minority. Ibsen had something remarkable to say about this. The majority, he wrote, has never been right. It has never been enough for the multitude to win, by force of numbers over the few; it has always been necessary for them to punish (as they do abroad now, for thinking "wrong thoughts") and to gloat. And so the torturers of Gloucester said, when they had put his eyes out, "Where's all thy lustre now?" "All dark and comfortless," said Gloucester. We may speak of "the great unwashed" disparaging-

ly, or we may think vox populi vox Dei. It may not be important. But when we see the crowds in the square and the dictator on the balcony, we know the truth. Ibsen was right, of course. To be defeated at the polls is no disgrace. In our hearts we know we are right and we will say so, loud and clear, as loud as Galileo's whisper as he was about to be burnt at the stake for saying the earth moves and he could not, for the life of him, keep silent, and said it does, too, move.

What is the voice of the people? It can be the Mets in last place and they succeed financially. It is the singers who admit they can do better, but they know "what the public wants." And it has become the completely irrational and greatly exaggerated cry for Medicare. It is the voice of political expediency and has not the ring of truth. The grocer does not reduce his prices according to one's age, nor does the clothier, nor does the landlord. Strong central government sounds good to those who do not think, but as central government gets strong, the governed become weak. "Do we need elections?" asked Castro, and the people roared "No!" Well, with Stevenson's young complainant, we "get up at night." No one else does. We charge less when our patients are poor. No one else does. We work without recompense when necessary. No one else does.

We want the best, says the public. But they have always had it, and while we may not always say what we think, we ought to be able to say they do not deserve it. In England, medical students no longer come from doctors' homes. And here and there, while it may not be fashionable to say so, they are not always the top students they once were. Where pupils interested in mathematics and physics once entered medicine, those attracted to medicine now seem to study physics and math. Well, we have had nonphysicians foisted on us. We, and we alone, now feel the heavy thumb of governmental dictatorship. Things change, but of all the wonderful sayings that have well stood the test of time, the best is this: you get what you pay for. If the medical care of this country suffers, those who have brought it about can hardly be unaware of what they have done. Perhaps they will pay for what they get. Our medicine has been the very finest in all the world. It should not become a political tool.

Long ago, slaves were doctors. The joke is too obvious, and far too serious. Our tormentors' demands have been unconscionably arrogant and humiliating. It has been said that the AMA is our union. But when do we get time-and-a-half or double-time for overtime? Or portal-to-portal pay? Or our birthdays off? Or a forty hour week? Or thirty? Or twenty? Or free medical service for our families? Or for us? When do others charge less because the patient is poor? When does anyone else charge what the government tells him to charge? And are we not labor? Do we not work with our hands? In God's name, what are we, but labor? But our fees become fixed, and our charges are reduced; others' strikes never stop and they force the price of everything to rise. And they remind us that *we* are doctors and may not strike. They rebuke us for our ethics on the one hand, and they remind us of them on the other.

But we retain our dignity. The image of the doctor, as *we* see the image, is what is important. We are every inch the doctor we once were, and a great deal more. We are not the doctor in the old picture, bringing comfort and little else to the sick child. Our surgery is bolder, our medicine more specific, our therapy more successful. And our ethics never better.—Frank Cole, M.D., Editor. Reprinted with permission from *The Nebraska State Medical Journal* 50:411-12, August, 1965.

## Students Flunk Freedom Test

LAST month's issue of "Action" magazine, published by the U. S. Junior Chamber of Commerce, reports on a survey taken in several leading colleges to determine the trend of political and economic thinking among the nation's youth who are being exposed to higher education.

The results compared with widely publicized surveys taken earlier among high school students would indicate that atten-

dance at college doesn't add very much to an understanding of the system under which we live and enjoy the blessings of freedom, or of the free economy which has produced so much abundance that virtually everyone who wants it can get a college education.

For example, on basic questions of individual freedom:

- 84% do not think that patriotism is vital and plays an important part in our lives.
- 71% do not believe an accused person has the right to face his accuser.
- 41% do not believe in freedom of the press.
- 40% would deny certain groups the right to assemble peacefully.
- 34% believe that certain persons should be denied the right of free speech.

In the area of economics:

- 62% think the government has the responsibility to provide jobs.
- 62% believe a worker should not produce all he can.
- 61% do not think the profit motive is necessary to the survival of free enterprise.
- 56% voted for close government regulation of all business.
- 53% believe in government ownership of banks, railroads and steel companies.

— Excerpted from *Politics*, Vol. 1, No. 4, May-June, 1965.

## Editorial Notes...

**Medical school dropouts in the decade from 1949 to 1958 varied from 6.65% in 1950 to a high of 10.43% in 1958.** The overall average was 8.69%. The rate of non-academic dropouts was surprisingly constant and averaged 3.58%. Academic reasons for leaving school accounted for a slowly increasing number, starting at 3.62% in 1950 and rising to almost twice that (6.54%) in 1958. Data for more recent years are not available since over eight percent of those who entered medical school in 1959 are still attending. While the dropout rate appears high, it is considerably lower than rates for most other graduate schools.

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**Hospitals are urged to maintain a high level of smallpox immunity among hospital personnel.** There is a low level of immunity among Americans. Due to the speed of air travel, a person may travel to the United States in the incubation stage of the disease and become diagnosable only after arrival. There have been 104 cases of smallpox in this country since 1946. Eight cases were persons arriving from abroad; the other 96 cases resulted from exposure to the eight introductory cases. Since the members of hospital staffs will be the ones most likely to be in contact with newly-arrived cases of the disease, their immunization status should be up-to-date.

**Anti-hemophilic globulin can be of the greatest importance in the treatment of major bleeding episodes or when major surgery is necessary but its use has been limited by its high cost.** Recently it has been found that a highly concentrated preparation of anti-hemophilic globulin may be made by quick freezing and slow thawing. The resulting product does not require sterilization and may be preserved by refreezing. It is called Cryoprecipitate Anti-Hemophilic Globulin and is from 20 to 30 times as potent as normal fresh plasma. The plasma or blood from which the a-h globulin is removed may be used for other purposes. It may be prepared by most blood banks and is available commercially.

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**U. S. pharmaceutical manufacturers last year had sales totaling $3.7 billion, and paid taxes of $375 million to the federal government and $130 million to the states.** The federal taxes exceeded the amount voted for the National Cancer Institute, the National Heart Institute and the National Institute for Allergy and Infectious Diseases. The industry has an investment which averages $45,200 for each of its production workers, more than double the all-industry average.

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**Men who work for large organizations usually move rather frequently and their**

**families suffer transplantation difficulties.** The Brattleboro Retreat, a private mental institution in Vermont, is begining a long-term study, together with the University of Vermont Medical School, to determine the effect of management policies upon the family. Their staff members already have an insight into the problem as a result of their contact with patients cared for in the institution's out-patient clinics in surrounding towns. They will have an advantage in their study of the problem, due to the cooperation of psychiatrists from a large organization which moves families frequently—the Armed Forces. ◄

## About Our Cover



"While this vaccine discovery was progressive, the joy I felt at the prospect before me of being the instrument destined to take away from the world one of its great calamities, blended with the fond hope of enjoying independence and domestic peace and happiness, was often so excessive that, in pursuing my favorite subject among the meadows, I have sometimes found myself in a kind of reverie.

"It is pleasant for me to recollect that these reflections always ended in devout acknowledgements to that Being from whom this and all other mercies flow."—Edward Jenner, M.D., (1749-1823).

Our sincere thanks to Parke, Davis & Company for allowing us to reproduce one of the paintings from their "History of Medicine in Pictures" series.©—J.F.S.

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KENNETH O. NEUMANN, M.D.

President

Indiana State Medical Association

1965-66

Dr. Kenneth O. Neumann, well known Lafayette general practitioner, began his term as president of the Indiana State Medical Association October 14. He accepted the presidential gavel on that date from Dr. Joe M. Black, Seymour, in the Murat Temple.

Dr. Neumann was graduated from the Indiana University School of Medicine in 1938 and after two years in hospital work, entered general practice in Lafayette. He served as a medical officer in the Army from 1942 to 1946 and was discharged with the rank of major.

Dr. Neumann has served two years as Chairman of the Council and as a member of the Executive Committee. Previously, he had represented the Ninth District as councilor for eight years. In addition, he has served as president of both the Tippecanoe County Medical Society and the Indiana Health Officers Association.

He has also served as chairman of the Section on Public Health and Preventive Medicine and has been a member of the Commission on Legislation, the Commission on Inter-Professional Relations, the Council Liaison Committee with Blue Cross and Blue Shield and the Student Loan Committee.

Dr. Neumann is an active staff member of both the Lafayette Home Hospital and St. Elizabeth Hospital and has served as president of the medical staff of both hospitals. He is currently the Tippecanoe County Health Officer and a director of Mutual Hospital Insurance, Inc., (Blue Cross), as well as a member of its executive board. He is also a member of the I-HOPE board.

Active in political and civic affairs, Dr. Neumann is a member of the Lafayette Chamber of Commerce, the Lafayette Country Club and the Immanuel United Church of Christ. He is married and has two children — a daughter who is a fourth grade teacher in Harcourt School, Indianapolis, and a son in high school in Lafayette.

# President's Page

## *Time and Dollars Needed*

We must all understand that the Medicare law is only the beginning. Other plans will surely follow. We must not permit ourselves to be "mouse-trapped" into blind compliance.

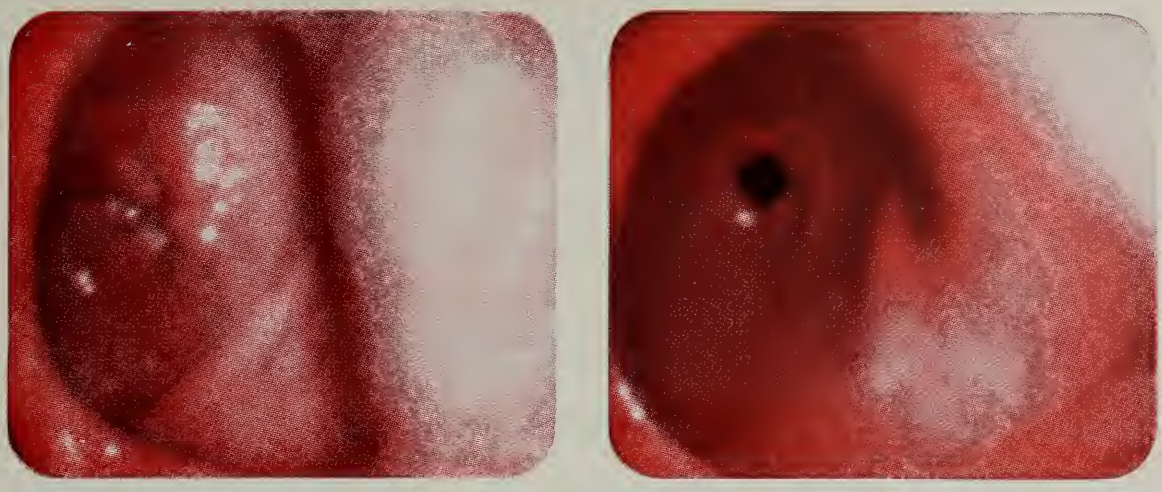


Each physician must devote more time and effort to political activity. We must develop contacts with our political leaders as well as discuss our views with our patients. Through increased participation in discussions and meetings outside the realm of medical sessions, we can not only help mold opinion favorable to us, but can more capably ascertain problem areas for organized medicine and the individual physician.

In the past, physicians have felt that politics was beneath their dignity. Either this attitude must change or physicians will finally be subservient to those who *do* take the time to participate and invest their money in "affairs politic."

I hope that each of you will give serious thought and will take time *now* to involve yourselves in medical, civic and political affairs. Your time and your dollars invested in these areas will determine whether we can be free. Only YOU can provide the answer.

H. O. Neumann M. D.



## Intragastric photography studies[1]

**A/** E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

**B/** Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.

# Now you can see Pro-Banthine® at work
## (propantheline bromide)

Pro-Banthine is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

Pro-Banthine produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthine. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superiority of Pro-Banthine which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

**Dosage**—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

**Side Effects and Contraindications**—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

*Research in the Service of Medicine*

# The Woman's Auxiliary

## REPORTS TO ISMA

Accepting invitations from county auxiliaries broadens the opportunity of becoming better acquainted. It is unfortunate that our busy lives do not permit closer relationships.



Subjects dear to the hearts of your wives are those concerned with raising your families in progressive communities. Discussion of the ascendency of venereal disease in our teenagers has been fanned by an article in "McCalls" September issue by Jessica Mitford, author of *The American Way of Death.* The article is worth reading — frightening in its implications and critical of TV's decision not to broadcast programs on the subject. The word "syphilis" was first broadcast on the air from an Indianapolis station around 1945.

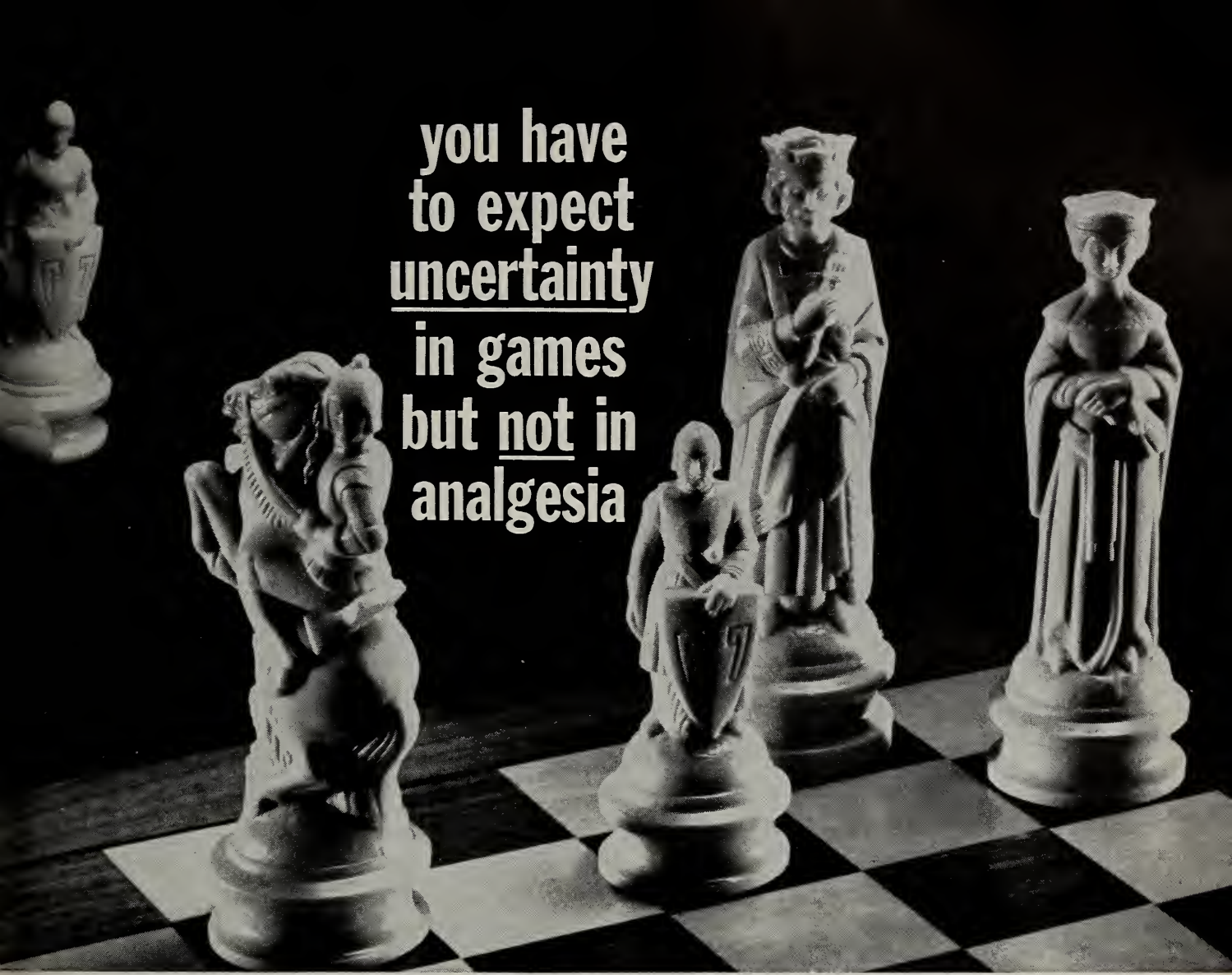
Driving through the country-side on the way to meetings also affords one the luxury of listening to radio programs never heard before. One such broadcast was an open line conversation between a moderator who merely answered the phone and identified the person speaking; he himself did not give any opinions or answers.

A young mother of five discussed the importance of measles serum for her children. Having read an article in "The Reader's Digest," she had learned of the damaging effects of measles and the availability of serum at a nominal cost. The article had quoted a cost of around a half dollar. Her family doctor had informed the mother that his cost was much higher, as the serum itself was expensive. She felt the price was prohibitive for her family of five children and wondered why the local physicians couldn't make the serum available as they had the Oral Sabin some months previous. This query set off a series of calls varying from "Do you want socialized medicine" to a discussion of research involved over a long period of years, the cost of beer, cigarettes, and on and on.

The role of the doctor's wife is not always a comfortable one, especially when criticism of doctors and their "exorbitant fees" comes into a discussion. There is an article in the September-October issue of "MD's Wife" which gives us an excellent answer to this criticism. "Is the Price Right" on pages 14 and 15 is most informative in presenting factual answers with extreme subtlety. In case your wife hasn't glanced through the new bi-monthly magazine mailed to every medical auxiliary member, do tell her to take time to read this particular article — it's short and informative.

While attending the Michigan State Medical meeting in Detroit in September, we learned that they have included the payment of their wives dues in with their own. This assures that each of their wives will be better informed on the medical front.

Ruth V. Dunstone




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# Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
*Indianapolis*

### Is Fluothane (Halothane) Hepatotoxic?

A three-year study of possible toxic effects of halothane anesthesia on hepatic function is reported by Mushin, et al.[1] Since 1958, this question has been on the minds of anesthesiologists and this well-developed study is of considerable value in obtaining an answer. The study consisted of 15,747 halothane and 6,123 non-halothane anesthetics. The clinical records and liver function studies of these patients were analyzed. No statistical differences were found between the two groups as far as liver function tests, morbidity or mortality were concerned. There was no evidence suggestive of a specific toxic effect or allergic reaction from the halothane. This appears to be a well-designed study and should be reassuring as to the safety of this effective agent.

### Menopause Four Years Later Than in 1850

Fairly wide variation in the age of onset of the menopause has been well recognized for many years. The study by Frommer[2] indicates that there has also been a change in the average age of onset in the past century. The average menopausal age was found to have increased to 50.1 years for the decade of 1951 to 1961. This is an increase of about four years as compared with that recorded in 1850. Obviously, a study such as this has certain inborn errors, but the author has done his best to take these into account and has turned out an interesting study. The explanation of the significance of the study and basic physiology involved must be mainly speculative, however.

### German Measles and Congenital Defects

A major unanswered question regarding therapeutic abortions has concerned the actual incidence of fetal abnormalities born of mothers who have had rubella during the first trimester of pregnancy. Many have speculated that the incidence of abnormalities is not nearly as high as had been claimed previously. Sheridan[3] has attempted to shed light on this problem in her report of a prospective study of 578 such pregnancies during a three-year period from 1950-1952. Major abnormalities occurred in 15% of these children, and minor abnormalities were found in another 16%. These are listed as "outside estimates" since it is quite possible that unknown factors other than rubella accounted for the deformities. The children's intelligence did not vary from a normal range. Further long-term follow-up studies are planned, but it appears that these deformity rates are turning out to be lower than anticipated.

### High Glucose Curves, Hypertension and Coronary Disease

Standard glucose tolerance tests were performed by Nye[4] on a group of 107 hypertensive patients. It was found that 35% of the patients who also had coronary artery disease had abnormally high curves. This compared with 16% abnormal curves in patients who clinically were free of coronary artery disease. Speculation can be made regarding the presence of sub-clinical diabetes of fairly long standing in these patients which played a role in the pathogenesis of their coronary artery disease. It would be interesting to see an extension of this study using a cortisone-glucose tolerance test.

### Long-term Anticoagulants and Reinfarction Rates

A further report of a huge combined study on the value of long-term anticoagulant therapy for coronary thrombosis is reported.[5] This study includes several hundred patients and is an on-going study in England, having been undertaken in 1955. The reinfarction rate in males was lower in the anticoagulant treated group than in

the control group, and this was even more significant in males below the age of 55. No difference was noted in the two groups of females, but the number of female patients was too small to draw any definite conclusions. There have been similar studies reported in this country, and it will take studies of this magnitude over a number of years to resolve the question of the value of long-term anticoagulant therapy in coronary artery disease.

### Vagotomy and Duodenal Ulcer

An evaluation of complete vagotomy in the treatment of duodenal ulcer is presented by Clark, et al.[6] They report a large series of patients treated with gastroenterostomy and complete vagotomy. They found there was a lowered incidence of recurrent ulceration in these patients but that it did not confer complete immunity from recurrence. They also found that the unpleasant side-effects after surgery were not increased by the procedure. The authors felt that poor drainage procedures were a greater cause of poor results than was vagotomy.

### Plasma Renin, Aldosterone and Progesterone

Plasma renin determinations were made by Brown, et al.[7] during various phases of the menstrual cycle in nine nulliparous female medical students. A small, but significant rise in the values was found during the luteal phase. This coincides with a previously described rise in aldosterone excretion during this same phase. The authors speculate that the renin increase may be mediated through a rise in progesterone excretion at this time in the cycle.

### Thyrotoxicosis in Children

Thyrotoxicosis is not seen very often in children but when it is, it presents a therapeutic problem. A series of 70 such patients was studied by Saxena, Crawford and Talbot.[8] Although diagnosis of the condition was reasonably easy, all forms of therapy left much to be desired. Radioactive iodine was not used in this young age group. Antithyroid drugs had a high rate of toxicity and failure; therefore, even though subtotal thyroidectomy was also far from perfect, the authors judged it to be the most suitable. The authors hope that radioactive iodine may be more suitable and better handled in the future in this troublesome therapeutic dilemma.

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# The Coliseum Disaster: Aftermath at Methodist Hospital*

JOHN V. THOMPSON, M.D.
*Indianapolis*

THE Indianapolis Coliseum explosion occurred near the end of a public performance of an ice show which was attended by families of good standing in the community. This undoubtedly affected the cooperative effort put forth by those in attendance at the scene as well as aiding the rapid evacuation of the injured and later hospital control. This circumstance on the other hand contributed a great deal to the tragedy of the situation.

The disaster was the result of an explosion with accompanying fire. The injuries were thus principally those caused by blast and burns. Persons were literally thrown through the air and many were trapped beneath concrete and steel debris.

The hospitals with one exception received no notice of the disaster until patients began to arrive, or until this information became available through radio and television broadcasts. The administrator of the Methodist Hospital was notified by a passing physician.

Stimulated by the local Trauma Committee of the American College of Surgeons, pre-existing disaster plans and emergency room facilities had been well prepared. These were immediately put into action by the hospitals. Practically all casualties had been transported to the hospitals within two hours of the explosion. These institutions, however, had no concept of the number of victims to be expected until near the end of the arrivals.

### Preparedness Pays

Having had previous experience with groups of casualties, the house staff of the Methodist Hospital immediately went into service according to pre-arranged plan. A resident physician acted as the triage officer until the arrival of attending staff physicians. Fortunately, the majority of the house staff was quartered in an adjacent building provided by the institution.

The attending medical staff of this 978-bed hospital, having heard of the catastrophe through the news media, voluntarily went to the hospitals in sufficient numbers to meet the situation. The staff members then went to areas where their services appeared to be needed and sought work best suited to their talents.

The process of physicians reporting to a central point for assignment by the president of the staff (or the chief of service) to patient care teams and as consultants appeared to be of considerable value. Additional orthopedic surgeons and neurosurgeons were summoned as the severity of some of the injuries became apparent. The maintenance of a call list of key physicians was important. All patients were rapidly and efficiently cared for according to standard medical procedure.

Off-duty nurses, public health and private nurses as well as other paramedical personnel voluntarily came to the hospital and performed with the capability that physicians have long known they possess. A number of the 50 house physicians and 350 student nurses were held in reserve to cover the hospital wards the next day.

A security guard was placed around the hospital and traffic control was established. A visitor's center with informational services and a press area were set up in an adjacent building. Necessary additional supplies were furnished from central service, housekeeping and laundry departments as well as from the pharmacy.

Previously assembled portable chests of drugs and supplies prepared for auxiliary areas of the hospital were found to be of great assistance. The dietetic department

*Presented before the 15th National Conference on Disaster Medical Care sponsored by the Committee on Disaster Medical Care of the American Medical Association in Chicago, November 7, 1964.




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**PRECAUTIONS AND SIDE EFFECTS:** Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

**WARNINGS:** Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

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Continued

prepared for the additional patient load and established a visitor's canteen. Essential personnel of the hospital were called from a prepared list. Additional telephone lines for informational services were installed by the telephone company. Communications throughout the regular hospital system remained adequate for the situation. All personnel performed well in the processing and servicing of patients.

### Registered, Tagged, Treated

As the patients rapidly arrived in large numbers at the hospital, they were registered and tagged in the emergency room. The triage officers classified and routed patients to designated areas of the hospital. Tentative diagnoses were written on the large informational tags. Those not requiring hospitalization were sent to the outpatient department where they were further examined and lesser injuries were treated. Persons needing immediate major attention were either treated in the emergency room and sent elsewhere in the hospital, or were sent directly to the operating room suite and adjacent shock recovery room. Many of them were submitted to x-ray examination en route. A third group of patients, in no immediate danger after emergency care was administered, were sent to a large physiotherapy department until they could be further evaluated, treated and hospitalized, if necessary. This area also was utilized as a shock treatment center for patients awaiting x-ray examinations as it was adjacent to the x-ray department.

The assignment of a student nurse in the emergency room or a member of the paranursing personnel group to accompany each patient through the hospital until reaching a permanent bed was considered expedient. Such personnel could be utilized to remove clothing for proper examination, see that orders were transcribed and consummated, to record any change in the patient's status and call a physician if necessary.

It was not necessary to invoke a fourth category of patients, that is, those so critically injured that life expectancy was poor, or those whose condition demanded prolonged complicated treatment that required delay until the other classes of patients were processed. It was likewise unnecessary to prepare other large reserve areas such as lecture halls to accommodate patients, nor to discharge patients prematurely although a plan was prepared for this eventuality. Scheduled admissions to the hospital were delayed however for one or two days.

### Triage Teamwork

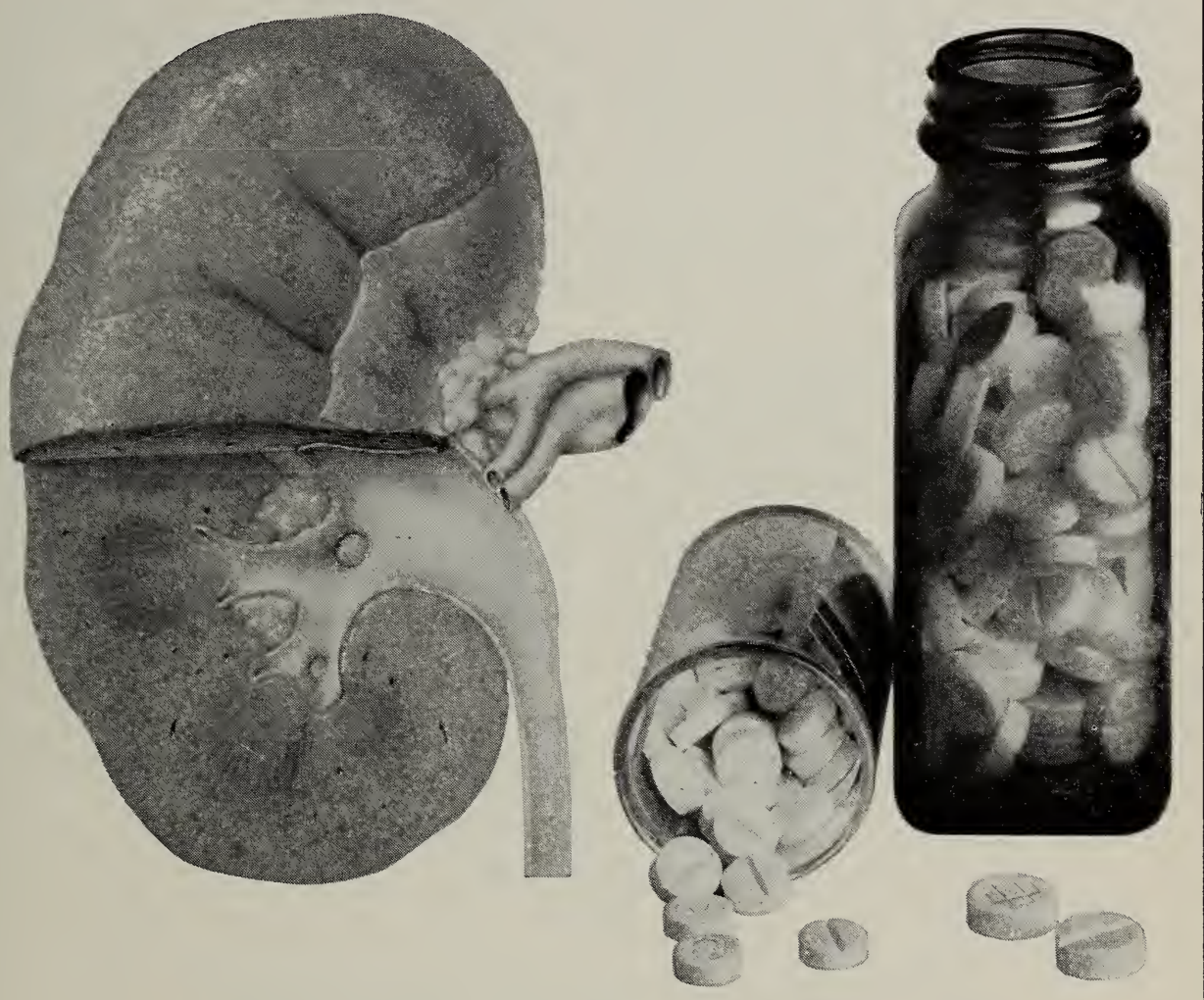
Physicians of all segments of the profession were soon divided among the patients in the shock areas. They observed the patients' progress, clarified the diagnoses, treated the shock and attended to their immediate needs. As specific problems arose, specialists were requested to further evaluate them and treat the patients as necessary. If immediate surgical intervention was deemed advisable, the patient was promptly taken into the operating room. All major operating units were available shortly after the arrival of the patients. Twenty-three major operative procedures were performed between midnight and daylight. Most of the regularly scheduled surgery for the next day was carried out on time.

The availability and processing of blood presented concern to the laboratory because of the time factor involved for a limited technical personnel. This was solved by centralizing the blood collection from volunteers at the Indiana University Medical Center, thus relieving the Methodist laboratory of this phase of the problem. Sixty units of blood were administered in the first six hours following the catastrophe. Teams for the administration of fluids worked well in the shock areas and in the receiving room.

The department of radiology instituted the practice of writing brief interpretations in large letters on the envelopes containing the film. These were forwarded with the patient to the shock and treatment areas, thus expediting the patient's care a great deal. The department processed 110 patients that night.

Continued

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## COLISEUM DISASTER

Continued

Tetanus prophylaxis was well carried out and no case of this dangerous disease developed among the victims in this hospital or elsewhere.

Practically all of the patients immediate needs had been met within four hours after the blast. An administrative and staff committee temporarily assigned physicians for the most part to the patients for whom they had cared during the emergency to insure immediate follow-up care. Other staff physicians likewise were assigned as necessary until the family doctors of those living in the community could be notified of their admission.

The total casualties numbered 436 persons, 54 of whom died at the scene and eight more who were dead on arrival at the hospitals. The institutions of the metropolitan and surrounding areas admitted 164 patients for treatment as inpatients. (One patient dead on arrival was apparently classified for administrative purposes as an admission at one hospital and accounts for the discrepancy in some previously published figures). There were in addition 209 persons treated for injuries not requiring admission. Methodist Hospital admitted 64 patients or 39% of the inpatient casualties. Its outpatient service processed 55 persons or 27% of the injured patients not requiring admission.

A study was made of the type of injuries sustained by the 135 patients admitted to five of the metropolitan hospitals. These data are depicted in Table 1. Two of the hospitals admitted 105 of the 135 patients. Orthopedic injuries predominated as 86 such injuries occurred alone or in combination with other injuries. Neurologic injuries were the next most frequent as 33 were observed alone or in combination with other types. Most of them, oddly enough, were confined to one hospital. Likewise, thoracic injuries ranked high on the list with 29 recorded. Only 10 burns of varying degree were noted among the patients admitted. Surprisingly no major abdominal injuries were seen in any hospital, but two such cases were known to have been among those killed by the explosion.


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TYPE OF INJURIES ADMITTED TO EACH HOSPITAL

| Type | Methodist | St. Vincents | Community | St. Francis | General | Total |
|---|---|---|---|---|---|---|
| Orthopedic | 20 | 18 | 6 | 1 | 8 | 53 |
| Orthoped. — Neuro. | 3 | 2 | 1 | 1 | 1 | 8 |
| Orthoped. — Thoracic | 15 | 1 | | | | 16 |
| Orthoped. — G. U. | 1 | | 1 | | | 2 |
| Orthoped. — Burns | 2 | 2 | | | | 4 |
| Orthoped. — Oral | | | 3 | | | 3 |
| Neurologic | 14 | 1 | 2 | 2 | 1 | 20 |
| Neuro. — Thoracic | 2 | 1 | 1 | | | 4 |
| Neuro. — Burns | 1 | | | | | 1 |
| Thoracic | 1 | 7 | | | 1 | 9 |
| Oral | 1 | 1 | | | | 2 |
| Burns | 1 | 4 | | | | 5 |
| General | 3 | 1 | 1 | | 3 | 8 |
| Inpatients | 64 | 41 | 12 | 4 | 14 | 135 |

**Table 1**

Four deaths were recorded among those patients admitted to Methodist Hospital. One was due to pulmonary edema and myocardial failure in a female, 81 years of age, suffering from multiple fractures and a crushed chest. The second was due to cerebral edema following skull fracture and a subdural hematoma. Another patient expired from renal failure complicating severe burns and multiple fractures. The other death occurred in a man, 72 years of age, due to myocardial infarction complicating multiple fractures.

Thirty-seven of the 64 patients admitted remained in the hospital two weeks after the catastrophe. The last hospitalized patient among those unfortunate persons was discharged exactly one year after the disaster.

It must be concluded that physicians, hospitals and their personnel acted with remarkable efficiency, dispatch and with the utmost consideration of the patients under rather trying circumstances. ◄

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*Interpreted by*
*ROBERT HOLLOWELL, LL.B., legal counsel*
*Indianapolis*

Mr. James A. Waggener
Indiana State Medical Association
3935 North Meridian Street
Indianapolis, Indiana 46208

Dear Mr. Waggener:

I have your letter of July 13 enclosing a form of medical report [of driver fitness] for automobile insurance, which is apparently used by the three insurance companies named therein, all of which have the same address at Battle Creek, Michigan. Your questions concern the potential liability of a physician to either the applicant or to the insurance company in filling out and signing this form.

This involves different questions than the ordinary malpractice question or case, and I have been unable to find any decided case in Indiana that I would consider in point. The closest rule would be that involved in a patient's claim against his physician for erroneous diagnosis. There are numerous decisions on that question generally. The general rule is stated in 41 American Jurisprudence, *Physicians and Surgeons*, Sec. 92, Page 209, as follows:

> "*Diagnosis*: — It is one of the fundamental duties of a physician to make a proper skillful and careful diagnosis of the ailment of a patient, and if he fails to bring to that diagnosis the proper degree of skill or care, and makes an incorrect diagnosis, he may be held liable to the patient for the damage thus caused just as readily as he must answer for the application of improper treatment. This is a matter of statutory enactment, in effect at least, in some jurisdictions, as to unlicensed practitioners as well as those who are licensed. A physician or surgeon does not insure the correctness of his diagnosis, but his responsibility in diagnosing a patient's malady is to use ordinary skill and diligence and to apply the means and methods ordinarily and generally used by physicians of ordinary skill and learning in the practice of the profession to determine the nature of the ailment, and to act upon his honest opinion and conclusion."

Ordinarily, on making an examination and report, the physician gives merely his best opinion. I do not like this particular form. One of the things I do not like is that it does not call for the physician's opinion but, as worded, constitutes the answers as statements of fact. In this connection, it involves statements which I do not believe a physician could state as an absolute fact, but upon which he could only give his opinion. There is, therefore, a danger that some court might construe this particular statement as being almost in the nature of a warranty to the insurance company of the facts stated.

Another objection is the broadness of certain questions, particular #1 and #5 [ascertaining general health and mental condition.] It seems to me that to give a considered answer to those questions would probably require a complete physical examination, probably in a clinic or hospital and with a large amount of laboratory work, in addition to which they get into fields which I believe the average general practitioner would refer to a specialist. Also, this form not only calls for the findings as a matter of fact, but also the physician's representation as to whether or not they

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Continued

would affect the applicant's mental and physical fitness to operate a motor vehicle.

To illustrate more specifically, question #2 relates to impairment of vision, which would be in the field of ophthalmology, although I assume most physicians could use or are equipped to use routine examination. More important is question #5 which goes into his mental condition, and then to relate that mental condition to an ability to drive. Again, question #1A is exceedingly broad as asking for any nervous, organic, or functional disease which has advanced or is likely to advance during the next twelve months to a degree that will affect safe driving. This question just about covers every conceivable phase of a complete medical examination.

In summary, I do not recommend that physicians use this form, but should use the ordinary report form stating the scope of the examination and the findings in the opinion of the physician, and let the company decide whether the effect of those findings would bear upon the applicant's ability to drive safely. This latter determination, it seems to me, involves factors other than medical, such as judgment, attitude, and such matters. ◄

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The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

*The unusual muscle-relaxant and analgesic properties of 'Soma'* make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

*Indications:* 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

*Contraindications:* Allergic or idiosyncratic reactions to carisoprodol.

*Precautions:* 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

*Side Effects:* The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

*Dosage:* Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

*Supplied:* Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

*Before prescribing, consult package circular.*

**for the relief of low back sprains and strains**

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# Report on Test of Performance Survey

*(One of a series prepared by Indiana Blue Cross-Blue Shield)*

Indiana physicians established an excellent record in participating in the 1964 Test of Performance Survey conducted by the National Association of Blue Shield Plans, coordinator of Blue Shield Plans in the United States, Canada, Puerto Rico and Jamaica. Indiana physicians and Indiana Blue Shield also ranked high in the test of performance.

The survey was the largest single study in the history of medical economics. Fifty-four United States Blue Shield Plans with an enrollment of nearly 42 million participated in the survey. These plans account for 83% of Blue Shield's United States membership. The survey was limited to a sample of physician services in the areas of surgery, anesthesia, medical and maternity. (All OB delivery claims have been excluded from the survey results included in this article.) These areas account for about 89% of the money paid by the plans that participated in the survey. Over 470,000 questionnaires, selected in a scientifically drawn sample, were sent to physicians in a six-week period from May 18 through June 26, 1964. These questionnaires inquired about physician's charges and Blue Shield's payments for selected services. Nationally, physicians returned better than 370,000 questionnaires, a response of nearly 80%.

In Indiana 14,000 questionnaires were sent direct to physicians, and an additional 1,000 direct to patients for auditing purposes. The response of Indiana physicians was slightly better than the national average, with better than 80% of the questionnaires returned.

The survey showed that Blue Shield nationally paid 89% of the cost of physicians' services for members possessing its best group certificate. In Indiana, our best group certificate paid 95%, six percent above the national average. Our best group certificate is the county schedule approach, based upon the ISMA House of Delegates Resolution #26.

Nationally Blue Shield paid 82% of members' costs in its most widely held group certificate. In Indiana our most widely held certificate — the preferred schedule — paid 83% of charges.

All group business showed that both nationally and in Indiana, Blue Shield paid 79% of charges.

Nationally, Blue Shield's best non-group certificate paid 80% of charges, and Indiana's best non-group certificate paid 82%.

Indiana physicians are to be congratulated on the basis of their wholehearted cooperation in making this survey statistically successful, and for establishing records in the test of performance that in most instances are better than the corresponding national average. ◄

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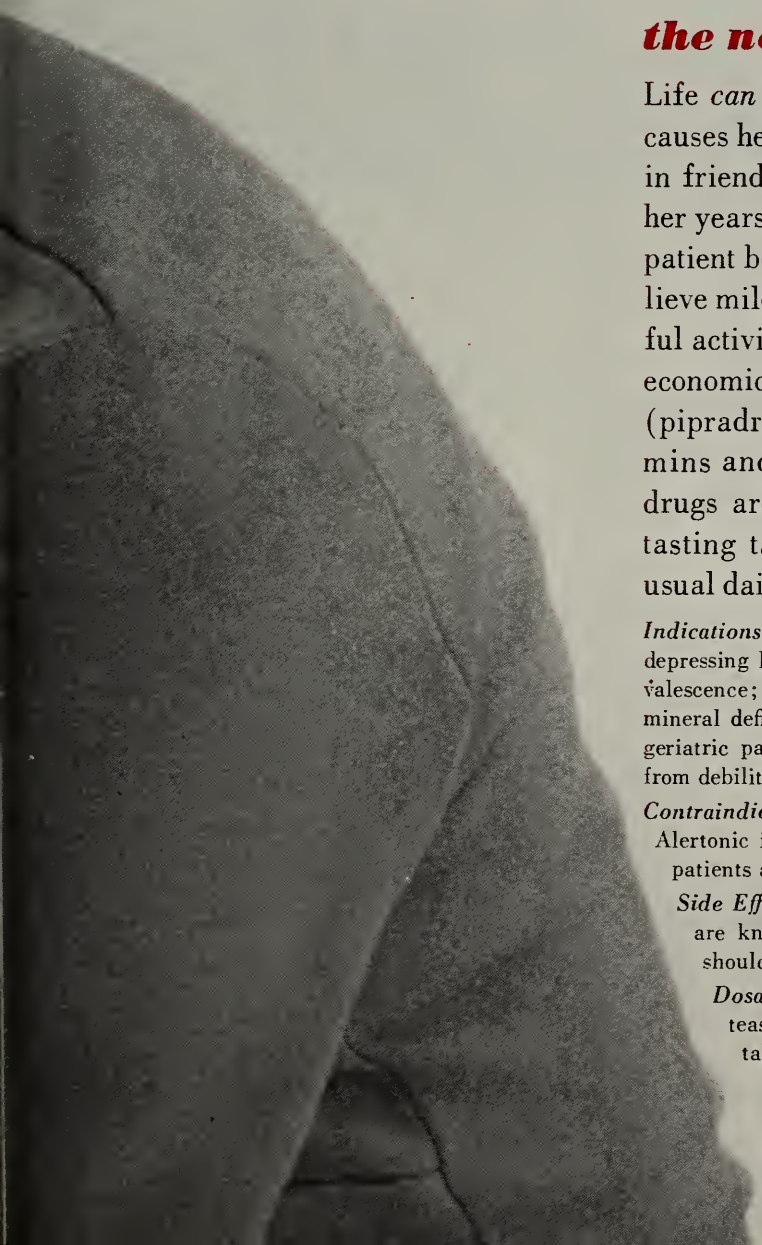
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*Multiple of adult Minimum Daily Requirement supplied.
†The need for these substances in human nutrition has not been established.



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*Indications:* 1. Functional fatigue such as that often associated with: a depressing life experience or stressful time of life; advancing years; convalescence; limited activity or confinement. 2. Poor appetite and vitamin-mineral deficiency as they occur in: patients having faulty eating habits; geriatric patients who are losing interest in food; patients convalescing from debilitating illness or surgery.

*Contraindications:* As with other drugs with CNS-stimulating action, Alertonic is contraindicated in hyperactive, agitated or severely anxious patients and in chorea or obsessive-compulsive states.

*Side Effects:* Reports of overstimulation have been rare. Patients who are known to be unduly sensitive to the effects of stimulant drugs should be observed carefully in the initial stages of treatment.

*Dosage:* Adults, 1 tablespoonful; children (over 15 years old), 1 to 2 teaspoonfuls; children (4 to 15 years old), 1 teaspoonful. To be taken three times daily 30 minutes before meals.

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# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—September, 1965

| Disease | Sept. 1965 | Aug. 1965 | Jul. 1965 | Sept. 1964 | Sept. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 1144 | 890 | 1077 | 799 | 733 |
| Chickenpox | 46 | 38 | 110 | 26 | 37 |
| Conjunctivitis | 105 | 127 | 96 | 96 | 44 |
| Diphtheria | 0 | 0 | 0 | 0 | 1 |
| Dysentery, Unspecified | 116 | 89 | 40 | 47 | 197 |
| Gonorrhea | 345 | 357 | 317 | 361 | 304 |
| Impetigo | 262 | 244 | 156 | 184 | 146 |
| Infectious Hepatitis | 42 | 43 | 47 | 35 | 38 |
| Infectious Mononucleosis | 63 | 27 | 38 | 32 | 10 |
| Influenza | 543 | 194 | 905 | 299 | 253 |
| Measles (Rubeola-Rubella) | 86 | 123 | 144 | 96 | 88 |
| Meningitis, Meningococcal | 2 | 1 | 3 | 5 | 6 |
| Meningitis, Other | 2 | 5 | 3 | 11 | 8 |
| Mumps | 58 | 70 | 116 | 96 | 106 |
| Pertussis | 17 | 11 | 10 | 40 | 43 |
| Pneumonia | 260 | 112 | 124 | 152 | 99 |
| Poliomyelitis | 0 | 0 | 0 | 4 | 0 |
| Streptococcal Infection | 549 | 321 | 421 | 395 | 199 |
| Syphilis | | | | | |
| Primary & Secondary | 5 | 3 | 1 | 6 | 2 |
| All Other Syphilis | 97 | 88 | 81 | 94 | 86 |
| Tinea Capitis | 21 | 7 | 16 | 4 | 4 |
| Tuberculosis (Active) | 82 | 114 | 75 | 89 | 79 |


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# Annual Meeting Dates of Professional Medical and Allied Organizations

**AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION**
Date Nov. 28—Dec. 1, 1965
Place Philadelphia, Pa.

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 10-13, 1966.
Place French Lick, Indiana

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date May 3-5, 1966
Place Fort Wayne

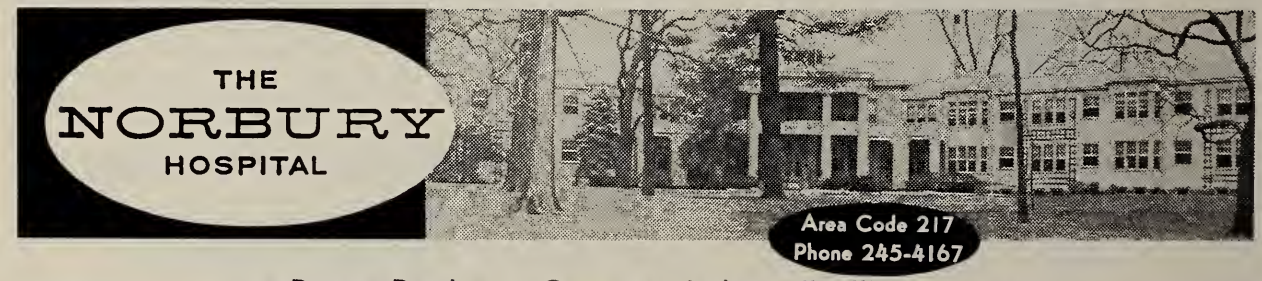
**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

**INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**
Date May 4-5, 1966
Place French Lick Sheraton Hotel, French Lick

**INDIANA OBSTETRICAL AND GYNECOLOGICAL SOCIETY**
Date Nov. 10, 1965
Place Marott Hotel, Indianapolis

**INDIANA CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS**
Date December 2, 3 and 4
Place Elkhart

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville


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Complete psychiatric treatment in an environment for cure. A 50 bed hospital with the most modern diagnostic and therapeutic equipment for the treatment of nervous and mental disorders.

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# ABSTRACTS

## BOOK REVIEWS

### THE PRACTICAL MANUAL FOR CLINICAL LABORATORY PROCEDURES

Henry C. Damm, The Chemical Rubber Co., Cleveland, Ohio, 1965, $12.50.

The Chemical Rubber Company, publisher of *The Handbook of Chemistry and Physics* and other chemical and mathematics handbooks, has published a five ring, loose leaf manual for use in performing and interpretating commonly performed laboratory tests. The manual includes procedures from blood bank, chemistry, hematology, histology, microbiology and urinalysis. Each section is color coded for rapid use and preceded by a stiff page index of the section.

The tests are described by an outline of the general principles of the test, equipment and reagents used, the step-by-step performance and interpretation. The common problems encountered are discussed when indicated. References to the original description of the tests are given in many instances. The editor and well qualified advisory board have compiled quite a well rounded practical manual of clinical laboratory procedures.

The manual is designed to be continued as a current reference with additions to the sections made as rapid advances are made in the field.

Medical technologists, pathologists and students of medical technology should find the manual of real value.

JAMES J. SULLIVAN, M.D.
Indianapolis

### CARDIOMYOPATHIES

Edited by G. E. W. Wolstenholme and M. O'Connor, Ciba Foundation Symposium, Little, Brown & Co., Boston, Mass., 1964, 136 illustrations, 428 pages, $12.50.

Just within the last ten years, a new cardiomyopathy has been discovered. Some 80% of this symposium is devoted to an exhaustive discussion of "hypertrophic obstructive cardiomyopathy," also called by numerous other names such as "pseudoaortic stenosis," etc. Now — with all deference to the brilliant panelists — there just isn't that much to say about this condition. As my old teacher, the immortal A. J. Carlson of the University of Chicago used to say, "With a diarrhea of words, there develops a constipation of thought" . . . .

In the less than 100 pages remaining, there are some trenchant comments on "endomyocardial fibrosis," "fibroelastosis," "Friedreich's disease," and a few pages on "viral myocarditis." The last was extremely good and should be read first by any one plunging into this volume.

Five or ten years from now, another symposium on the stated topic will be held, I'm sure. A happier balance will be struck, we hope—also, a lot more information will be available anent hypertrophic obstructive cardiomyopathy which has been the subject of the rather sterile debate summarized in this volume.

ARNOLD LIEBERMAN, M.D.
New York, N. Y.

## Abstracts From Various Literature, Prepared by AMA

### CHILDBEARING PRIOR TO RECOGNITION OF DIABETES

J. M. Malins and M. G. FitzGerald
*Diabetes* 14:175, (April), 1965.

A total of 12.6% of 2,348 children born to women who later developed diabetes had a recollected birth weight exceeding 10 lb. (4.5 kg), compared with five percent of a control group. The proportion of these heavy babies did not increase as the diagnosis approached and was as great 40 to 60 as 0 to 20 years before the diabetes was recognized. It was the same in each birth rank. Men show no increased tendency to father very large babies before the onset of diabetes. The stillbirth rate in the five years preceding the diagnosis of diabetes was 13.8%, but before that period the stillbirth rate was not in excess of that in the normal population.

### TOXIC DILATATION OF THE COLON IN ULCERATIVE COLITIS

A. Hemmati (Medizinische Universitäts-Poliklinik, Bonn, Germany)
*Fortschr. Roentgenstr.* 102:265-267, (March), 1965.

About 80 cases of segmented dilatation of the colon have been reported in patients with ulcerative colitis. This complication has been observed mostly since glucocorticoids and corticotropin were introduced into the therapy of ulcerative colitis, and so it has been assumed that a direct connection exists between the prolonged hormone therapy and the occurrence of toxic megacolon. The dilatation can be demonstrated by roentgenoscopy without contrast filling, in fact, oral or rectal introduction of contrast medium is dangerous and should be avoided. Conservative treatment should be tried for from three to seven days. Steroids can be given intravenously and the electrolyte economy must be carefully checked and adjusted. Anemia and hypoproteinemia should be counteracted by blood and plasma transfusions. Should dilatation increase despite these measures, partial or total colectomy or ileostomy should be employed.

### RESUSCITATION FROM CARDIAC ARREST AFTER ACUTE MYOCARDIAL INFARCTION

J. S. Robinson and G. Sloman (Royal Melbourne

Continued




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STRESSCAPS B and C vitamins in therapeutic amounts... help the body mobilize defenses during convalescence...aid response to primary therapy. The patient with a severe infection, and many others undergoing physiologic stress, may benefit from STRESSCAPS.

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| Niacinamide | 100 mg. |
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| Vitamin $B_{12}$ Crystalline | 4 mcgm. |
| Calcium Pantothenate | 20 mg. |

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

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# ABSTRACTS

Continued

Hosp., Victoria, Australia)

*Med. J. Aust.* 1:578-582, (April 17), 1965.

A series of 53 patients with cardiac arrest after a proved myocardial infarction is discussed, and a regimen for management is recommended. In 33 of the 53 patients treated, ventricular fibrillation was the mechanism of cardiac arrest. The best results are obtained in those patients with ventricular fibrillation, particularly when the underlying infarction has been mild. Asystole accompanies severe infarction or cardiogenic shock; hence, successful resuscitation with long-term survival is unlikely. The major steps in resuscitation are: (1) prompt external cardiac massage, (2) adequate ventilation with oxygen, (3) correction of the acidosis, (4) early ECG diagnosis, which should be followed by (5) appropriate electrical treatment of the arrhythmia. Good postresuscitation management is essential for long-term survival. The patients should be observed until their cardiac rhythm is stable, the tracheostomy tube has been removed and mobilization has commenced.

## HUMAN PRECARCINOGENIC CELL MANIFESTATIONS ASSOCIATED WITH POLYETHYLENE CONTRACEPTIVE DEVICE

J. E. Ayre (National Cancer Cytology Center, New York)

*Industr. Med. Surg.* 34:393-403, (May), 1965.

A polyethylene intra-uterine contraceptive device was inserted in two women whose cervical smears, one for a year previously, were cytologically normal. In both of these normal cases the smears suddenly flared into dysplasias and precancerous states and fulminated toward carcinoma in situ at a rate never previously seen by the writer in 25 years of cytologic research. In a second group of three patients with pre-existing, mild, latent dysplasia, the plastic device was followed by cellular progression, one at an alarming explosive rate of speed and two more slowly. These findings suggest a possible relationship between a polyethylene intra-uterine device and dysplastic cellular manifestations, the necessity of making cytological tests before and during the use of any device for contraception, and the choice of other, safer, technics of contraception.

## LINCOMYCIN AND STAPHYLOCOCCAL INFECTIONS

C. Grondin, M. St-Martin, and A. Potvin (Hosp. Hotel-Dieu de Quebec, Quebec)

*Canad. Med. Assoc. J.* 92:1062, (May 15), 1965

Lincomycin, a chemically new antibiotic effective against gram-positive organisms, was evaluated in vitro and tested clinically. In vitro testing indicated that lincomycin is especially effective against *Staphylococcus aureus*. Clinical testing showed that lincomycin was free of toxicity in a series of 18 cases of staphylococcal infection. Of particular interest was its pronounced effectiveness in nine cases of chronic osteomyelitis, one of which was of 15 years' duration and unresponsive to all other forms of antibiotic and surgical treatment.

## CONGENITAL SPINAL ANOMALIES IN INFANTS OF DIABETIC MOTHERS

S. L. Rusnak and S. G. Driscoll (221 Longwood Ave., Boston)

*Pediatrics* 35:989, (June), 1965.

Severe anomalies of the lumbosacral spine were observed in three infants of diabetic mothers. Seven similar cases were found among previous reviews of lumbosacral agenesis with histories of maternal diabetes mellitus. Many of the collected cases and all of the three personal cases showed other congenital defects. These observations suggest that progeny of diabetic mothers are specifically susceptible to major skeletal maldevelopment.

## GASTRIC FREEZING: A NEW CAUSE FOR GASTRIC ULCERS

R. A. Wolff

*Bull. Gastroent. Endoc.* 11:32-33, (May), 1965

In a series of 262 patients with peptic ulcer diathesis who underwent the freezing treatment, three suffered postfreeze gastric ulceration. Patchy areas of solidly frozen gastric wall, resulting in the destruction of tissue, contribute to this complication. The jet stream effect of an open-end tip inside the balloon is recognized as one cause

Continued

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TRANCOPAL is a "Tranquilaxant" which calms anxiety and tension, relieves muscle spasm, and enhances the analgesic effect of aspirin by subduing *emotional responses* to pain.

**NON-NARCOTIC ANALGESIC, with tranquilizing and muscle relaxant properties**

### In low back pain

**sciatica, lumbago; musculoskeletal pain associated with strains and sprains**

### In tension headache

**premenstrual tension and dysmenorrhea**

**Side effects** such as gastric distress, occasional weakness, sedation or dizziness may be noted. Ordinarily, these may be reversed by a reduction in dosage or temporary withdrawal of the drug. TRANCO-GESIC should not be administered to persons known or suspected to have an idiosyncrasy to acetylsalicylic acid.

**Dosage** for adults is usually 2 tablets three or four times daily, the suggested dosage for

Winthrop

for patchy overfreezing and resulting ulceration. With the use of a diffuse inflow system rather than the single inflow jet, the complication of postfreeze gastric ulceration has become less common. In 1,195 cases, using some form of spray tip, 12 postfreeze gastric ulcers resulted, for an incidence of 1%.

## LACK OF EFFECT OF TWO HEXACHLOROPHENE-CONTAINING SOAPS UNDER NORMAL HOSPITAL WORKING CONDITIONS

C. R. Macpherson (Department of Pathology, Ohio State University, Columbus), M. F. Sparkman and D. R. Whitney.

*Amer. J. Surg.* 109:699-704, (June), 1965

Two soaps containing 0.5% and 2.0% hexachlorophene, respectively, were compared with a standard hard bar soap for a five-week period. It was found that with normal hospital usage, neither of the soaps containing hexachlorophene offers any detectable advantage over the standard hard bar soap in the reduction of the superficial skin flora. There was neither a rapid fall in bacterial counts in the first week nor a progressive fall over the five weeks of the experiment. A statistical analysis of all possible factors including climatic variation showed no association which could explain this lack of effect. The authors did not test liquid hexachlorophene preparations, the disinfectant effects of which are firmly established. Contact with water precipitates hexachlorophene and prevents its transfer from soap to skin.

## STAPHYLOCOCCUS ALBUS IN WOUND INFECTION AND IN SEPTICEMIA

T. S. Wilson (Department of Surgery, University Hosp., Edmonton, Alta) and R. D. Stuart

*Canad. Med. Assoc. J.* 93:8, (July 3), 1965

Coagulase-negative *Staphylococcus albus* was considered to be the causal agent in 53 (4.4%) of 1,200 wound infections investigated in a large general hospital over an eight-year period (1957-1964). There was clinical evidence of morbidity in these patients, with fever, but the infection cleared spontaneously, usually in a week or two, and antibiotics were unnecessary. Of much greater importance was the finding of this organism in blood cultures on repeated occasions, with associated clinical septicemia. Six of 12 patients with this condition died, a mortality of 50%. Such data emphasize the tragic mistake of dismissing the report of *Staph albus* in a blood culture as "only a contaminant," and of failure to recognize that the organism can cause serious disease. This is particularly true in poor-risk patients and in those who have undergone cardiac surgery. ◄

**Hygroton®**
**brand of chlorthalidone**

**the longest-acting diuretic**

**Indications:** Many types of edema involving retention of salt and water.
**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.
**Warning:** With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
**Average Dosage:** One tablet (100 mg.) daily with breakfast.
**Availability:** Tablets of 100 mg. in bottles of 100 and 1000.
For full details, see the complete prescribing information.

*Dorhout Mees,E.J.,and Geyskes, G.G.: Acta med.scandinav. 175:703,1964.

Photos: A 59-year-old woman with hypertensive cardiovascular disease and edema resistant to low-salt diet and bed rest. The patient lost 8½ lbs. in one week with a single tablet daily of Hygroton, brand of chlorthalidone.

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*To lighten and clear blemished skin—without overbleaching or reactivity*

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*Eldoquin is mild:* 2% Hydroquinone proved to be a remarkably safe bleaching agent during use tests on 380 patients ". . . no case of sensitization developed (in these tests)."[1]

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*Contraindications:* Do not apply to skin which is affected by prickly heat, sunburn, depilatory application, or is otherwise irritated. Do not use near eyes or open cuts.

*Precautions:* Before initiating treatment, sensitivity tests should be made, as follows: Apply cream to an area about the size of a quarter on inside of upper arm and rub in well. Allow to remain for 24 hours. If no redness or itching develops, proceed with the treatment. Do not expose treated area to sunlight for extended periods.

*Supplied:* ½ oz. tube.

References: 1. Spencer, Malcolm C. and Becker, S. W., Jr.: **A Hydroquinone Effect,** Clinical Medicine 70:6 (June) 1963. 2. Spencer, Malcolm C: **Hydroquinone Bleaching,** AMA Archives of Dermatology 84:131 (July) 1961.

**PAUL B. ELDER COMPANY, Bryan, Ohio**




## *I. U. SCHOOL OF MEDICINE SOLICITS FOR 1965 MEDICINE FUND*

The 1965 campaign of the Indiana University School of Medicine fund is now underway and alumni and friends are being given another opportunity to contribute to help meet the needs of the School of Medicine. The fund program was established last year under the sponsorship of the Alumni Association, the administrative staff of the school and the Indiana University Foundation.

In last year's campaign $55,716 was received from more than 1,000 donors, representing some 300 communities in 37 states.



**D. S. Megenhardt, M.D. Indianapolis**

Dr. Dennis S. Megenhardt of the class of 1933, who served as national chairman of last year's program, has accepted this responsibility again for the 1965 campaign. Local chairmen have been appointed in 190 cities throughout the country. Eight-five of these communities are in the state of Indiana. Personal solicitation is scheduled during November and early December.

A booklet sent out recently by Dr. Megenhardt reviewed the recent progress of the I.U. School of Medicine and reported the specific uses which will be made of the funds contributed last year and in future years. The booklet also covers the various ways of giving for the benefit of the school. It points out that donations may be made without restriction or they may be designated for such special purposes as the John D. VanNuys Memorial Fund, the Cyrus J. Clark Memorial Loan Fund, the Betsey A. Barton Fund for Neurological Research and the Harmon Scholarship Fund.

All classes of the I.U. School of Medicine were represented in the contributions to the fund last year and a "rivalry" developed among the various classes. On Alumni Day last May 12, awards were given to the class of 1933 for the largest total contribution and to the class of 1914 for the highest percentage of participation.

Information on the fund is available through the Indiana University Foundation, Memorial Union Building, Bloomington.

## *New Health Insurance Pamphlet Explains Key Features of Policies*

A new publication which will help individuals and families analyze their health insurance has been published by the Health Insurance Institute. It is an eight-panel pamphlet titled "Guide to Your Medical Expense Insurance."

It describes the key features of hospital, surgical, physician (regular medical) and major medical expense policies which are provided by insurance companies on an individual and family basis. The publication also describes policy provisions, and furnishes definitions for many of the standard medical policy terms. Single copies may be obtained without charge from the Health Insurance Institute, 277 Park Ave., New York City 10017.

## New Robins Representative

Mr. John R. Dedden has joined A. H. Robins Company as a medical service representative. He will be assigned to the company's central division and will be working in the Fort Wayne area.

## *Doctors Asked to Contribute Service, Financial Aid to AMDOC*

Doctors interested in rendering medical and health services to needy areas of the free world or who are anxious to contribute money for such services may write AMDOC at 27 E. Canon Perdido St., Santa Barbara, California 93101.

AMDOC is a voluntary organization, and is not religious nor governmental. Its work has been mainly in Central America, South America, the Carribean, Africa and the Far East.

## Dr. Arbogast Named Director

Dr. J. L. Arbogast, professor of pathology and director of the Clinical Laboratory of Indiana University Medical Center since 1946, has been appointed as director of the Division of Allied Health Sciences of the School of Medicine.

The division includes programs in medical technology, medical records, occupational therapy, physical therapy, several options in public health and two-year programs in dental hygiene and x-ray technology. Additional programs will be added in the future.




**"LIFE BEGINS," the ISMA State Fair exhibit, was one of the most popular exhibits at the fair this year. The exhibit was designed to present a basic concept of the female anatomy associated with conception and birth. It featured actual human fetuses imbedded in plastic illustrating developmental stages in the womb from four weeks to the moment of birth. In addition, the exhibit depicted cell division following conception and concluded with a six-stage series showing the baby actually being born. Senior medical students from the I. U. School of Medicine were present to check blood pressures and members of the Marion County and ISMA Woman's auxiliaries acted as hostesses.**

## Indiana Physicians Asked to Join Fifty Year Club of American Medicine

The Fifty Year Club of American Medicine is a national organization of physicians who have practiced for fifty years or more. Its principle social function is a luncheon at the annual AMA Convention. Eligible doctors of Indiana are invited to join.

The initial fee is $5.00 for which the new member receives a lapel button, a Merit Certificate (suitable for framing) and a tie bar or tie clasp. Those interested should write Dr. J. H. McCurry, Secretary, Fifty Year Club of American Medicine, Cash, Arkansas 72421.

## New South Bend Clinic Building

Ground was recently broken for a new building for the South Bend Clinic. The new building will accommodate 25 doctors, and will be ready for occupancy in about one year.

## *New Brochure Available on Narcotic Drug Prescribing*

"Prescribing and Dispensing Narcotic Drugs" is the title of a brochure published by the Indiana Pharmaceutical Association to provide a brief refresher on narcotic law requirements for pharmacists and physicians.

It contains a list of Class A and Class B narcotic drugs by trade names. Distribution of the brochure will be made by all members of the IPA as a continuing education service.

## *Cleveland Physician Wins Award From American Writers Association*

Dr. Irvine H. Page, Cleveland, received the "Communications Award" of the American Medical Writers Association at its recent annual meeting in Detroit. The award was given for Dr. Page's many efforts in "promoting better communications among doctors and scientists and between the Congress and the public." ◄

# FUTURE MEETINGS, SEMINARS, COURSES

## *AMA'S First Air Pollution Medical Research Conference Set for 1966*

The relation of air pollution and chronic respiratory diseases will be discussed at length at the AMA's first Air Pollution Medical Research Conference to be conducted at Los Angeles in the Ambassador Hotel on March 2 to 4, 1966.

Six other medical and health organizations are cooperating with the AMA and will participate in the meeting. Those interested should write Department of Environmental Health, 535 N. Dearborn, Chicago 60610.

## Postgraduate Course in Laryngology, Bronchoesophagology in March-April

The Department of Otolaryngology of the Illinois Eye and Ear Infirmary and the College of Medicine of the University of Illinois at the Medical Center, Chicago, will conduct a postgraduate course in Laryngology and Bronchoesophagology from March 21 through April 2, 1966. This course is limited to fifteen physicians and will be under the direction of Paul H. Holinger, M.D.

Interested registrants write directly to the Department of Otolaryngology, College of Medicine of the University of Illinois at the Medical Center, P. O. Box 6998, Chicago, Illinois 60680.


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## *Cleveland Clinic Announces Course in Ophthalmology*

The Cleveland Clinic Educational Foundation will present a postgraduate course in ophthalmology January 12-13, 1966, at Cleveland.

Registration fee is $30.00. Further information on the course may be obtained by writing the Director of Education, Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

## *5th National Symposium Scheduled By Pennsylvania Heart Association*

The area of "Microcirculation" will be the topic of discussion at the Heart Association of Southeastern Pennsylvania's 5th National Symposium slated for Philadelphia's Sheraton Hotel, March 10 and 11, 1966.

The symposium is part of the Heart Association's professional education program designed to bring the latest available information from the research laboratories to the practicing physician.

Additional information may be obtained by contacting: Lyle L. Perry, Heart Association of Southeastern Penna., 318 S. 19th St., Philadelphia 19103.

## ISMA Members Invited to Scientific Meeting in Indianapolis

The Middle Section of the American Laryngological, Rhinological and Otological Society will conduct a scientific session at the Marott Hotel, Indianapolis, on January 22 and 23, 1966. Various aspects of otitis, hearing loss, vertigo, and laryngeal surgery will be covered.

On Sunday the 23rd there will be a symposium on acoustic neuroma with four nationally recognized authorities participating. All members of ISMA are invited to attend. Subscription rate for the entire meeting is $25.00 which includes two luncheons and one banquet. Registration fee alone is $10.00. For further information and a copy of the program write Dr. Marlow W. Manion, 601 Hume Mansur Bldg., Indianapolis 46204.

## American Group Psychotherapy Association Annual Institute

The American Group Psychotherapy Association will conduct its tenth annual institute on January 26 and 27, 1966 at the Bellevue Stratford in Philadelphia.

Theme of the meeting will be "Group Psychotherapy: Theory and Technic." Non-members are invited to attend. Registration fee is $65.00. For further information write the Association at 1790 Broadway, New York City 10019. ◄



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# County, District News

## Cass

Dr. Jack Warvel, Indianapolis, spoke on "Some Fundamentals on Diabetes" before the Sept. 6 meeting of the Cass County Medical Society. There were 36 members and guests present.

## Clinton

"The Use of Oral Contraceptives" was the topic chosen by Dr. T. A. Dykhuizen, of Frankfort, when he spoke at the Sept. 9 meeting of the Clinton County Medical Society. Thirteen members were present.

## Elkhart

Dr. William T. Close, former Chief physician of the Congolese Army, was guest speaker at the Oct. 7 meeting of the Elkhart County Medical Society.

## Fayette-Franklin

The Fayette-Franklin County Medical Society met Oct. 12 to see a film on endocrinology presented by Mr. Jack Knox of Eli Lilly & Company.

## Henry

Dr. George Lukemeyer discussed the "Present Status of Renal Transplantation and Artificial Dialysis" before the Sept. 16 meeting of the Henry County Medical Society.

## LaPorte

Dr. James M. Wilson of the Committee on Higher Education in Northern Indiana spoke on "The Northern Indiana Medical Center Project" at the Sept. 21 meeting of the LaPorte County Medical Society. There were 65 members and guests present.

## Owen-Monroe

Dr. Neal Baxter chose "Gemini Four and Gemini Five Space Medicine" to speak on at the Sept. 30 meeting of the Owen-Monroe County Medical Society.

## Shelby

"Hypertensive Retinopathy" was the topic of Dr. V. B. Scott when he spoke at the Oct. 6 meeting of the Shelby County Medical Society. There were 16 members present. ◄


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*(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.*

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DECEMBER 1965

The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication

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All articles must be typewritten, double-spaced with margins of one inch.

Photographs should be printed on glossy paper. Negatives cannot be used.

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Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 1802 North Illinois Street, Indianapolis 46202. All other communications should be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

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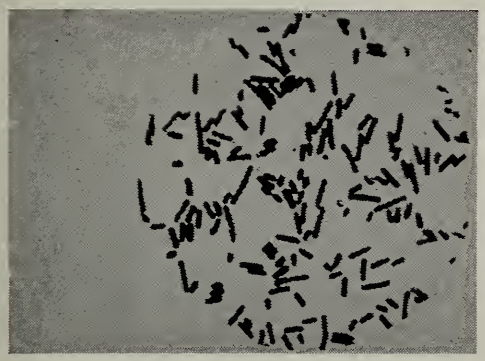
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on page 1340.

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| 3. | Marion Hagan, French Lick | Arthur L. Wagner, Jasper | French Lick, 1966 |
| 4. | Merritt O. Alcorn, Madison | Francis W. Hare, Jr., Madison | Madison, 1966 |
| 5. | Robert M. Fell, Rosedale | J. W. Somerville, Clinton | |
| 6. | William E. Murray, New Castle | Paul M. Inlow, Shelbyville | Shelbyville, 1966 |
| 7. | William C. Stafford, Plainfield | James H. Gosman, Indianapolis | |
| 8. | Lowell Painter, Winchester | Paul W. Sparks, Winchester | Muncie, June 1, 1966 |
| 9. | Harry T. Stout, Frankfort | Earl K. Williams, Frankfort | May 19, 1966 |
| 10. | Leslie Bombar, Munster | Louis Kudele, Whiting | |
| 11. | Donald W. Ferrara, Peru | Max M. Earl, Kokomo | Kokomo, Sept. 21, 1966 |
| 12. | Warren L. Niccum, Columbia City | Kenneth F. Isenogle, Fort Wayne | May 18, 1966 |
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# Butazolidin® alka

Each capsule contains:

| | |
|---|---|
| Butazolidin, brand of phenylbutazone | 100 mg. |
| dried aluminum, hydroxide gel | 100 mg. |
| magnesium trisilicate | 150 mg. |
| homatropine methylbromide | 1.25 mg. |

# in painful shoulder



# Geigy

**Therapeutic Effects**
The acute phase of subdeltoid bursitis, tendinitis and associated periarticular inflammation usually responds promptly and dramatically to phenylbutazone. Pain and tenderness may be relieved within 24-48 hours and mobility of the affected arm quickly restored. Full recovery is frequently achieved within 7-10 days so that therapy is generally of short duration. Calcific deposits are not specifically affected by treatment, but their presence does not appear to retard symptomatic improvement.

Phenylbutazone has not replaced physiotherapy, x-ray treatment, or local injections of hydrocortisone in the more chronic conditions, but it may advantageously be combined with these measures.

**Contraindications**
Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile, or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

**Precautions**
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

**Warning**
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

**Adverse Reactions**
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia are also possible side effects. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

**Average Dosage**
Initially, give 400 mg. daily (one capsule q.i.d), reducing this, if possible, when a favorable therapeutic effect has been obtained. If after one week there has been no response, discontinue the drug. Butazolidin alka contains antacids and an antispasmodic to minimize gastric upset.

**Note:** The physician should be fully aware of dosage, precautions, adverse reactions, and contraindications as contained in the complete prescribing information.

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## is *truly* a one shot measles vaccine.

An efficacy rate of 99% has been demonstrated with Schwarz Strain live measles vaccine (Lirugen). In recent clinical trials, Lirugen was administered without gamma globulin to approximately 13,000 children. In 1,405 of these children tested serologically, a conversion rate of 99% was reported. Close medical follow-up of inoculated children and controls showed no significant differences between mean maximum temperatures in the two groups. The incidence of high fever (103°F and above, rectally) attributable to the vaccine could be calculated at less than 1%, and the occurrence of mild, transient rash at less than 3%.

Lirugen is the most highly attenuated, but fully antigenic, live measles vaccine. Additional special passages of the original Edmonston Strain by Schwarz resulted in further attenuation which reduces systemic reactions so effectively that the use of gamma globulin with Lirugen is not needed.

Contraindications: Pregnancy; leukemia, lymphoma and other generalized malignancies; brain damage in children under one year of age; febrile illness; allergy to egg proteins, neomycin, or streptomycin. Precautions: Use cautiously in patients with a history of tuberculosis and patients being treated with steroids, irradiation, alkylating agents, and antimetabolites. Consult package literature before administering Lirugen.


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PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, U.S.A.




This summary of what is happening in Washington is prepared by AMA's Capitol office and air-mailed to *The Journal* on the ninth of each month preceding month of issue.

# MONTH IN WASHINGTON

WASHINGTON, D. C.—Federal agencies relaxed regulations for sale of Ipecac, ordered warning labels on certain antihistamines and cracked down on two patent medicines.

The Food and Drug Administration decided that the ready availability of Ipecac as a poison remedy outweighed the dangers of possible misuse and placed it back on the list of drugs for sale over the counter without a prescription.

Since Ipecac was placed on a prescription-only basis in January, 1964, the American Medical Association, the American Academy of Pediatrics and the Association of Poison Control Centers had urged that the vomit-inducing drug be returned to its former status.

Under the new ruling, FDA's Bureau of Medicine told the pediatrics group in Chicago that FDA decided it would be in the public interest to permit Ipecac to be sold over the counter in one fluid ounce bottles with special warnings on the dangers of its misuse.

The FDA also ruled that in the future antihistamines containing meclizine, cyclizine and chloro-cyclizine must bear labels warning against use by pregnant women without medical advice. However, they were left on the over-the-counter list. The FDA said massive doses of these drugs in test animals had produced congenital abnormalities, but there had been no evidence they have caused abnormalities in human babies.

Chas. Pfizer & Co., Inc., one of the companies that manufacture such antihistamines, protested the decision as not being "in accordance with the medical facts."

A House Government Operations subcommittee headed by Rep. H. L. Fountain (D., N.C.) recently had criticized the FDA for its handling of these antihistamines, contending that stronger warnings were needed and indicating that they should be prescription items.

The FDA ordered a halt to the sale of Alergimist "A" and "B", widely advertised as "cures" for hayfever, bronchial asthma, migraine headaches and allergic dermatitis.

The product has been actively promoted through newspaper, radio and TV ads without having been passed by the agency as either safe or effective. The product, sold without a prescription, was being distributed by the Brunson Corporation of Miami Springs, Fla. FDA said the same concern previously distributed Allergimist (with two "l's") until an injunction in September, 1964, was obtained against its interstate shipment.

The Federal Trade Commission ordered the J. B. Williams Co. of New York City to stop allegedly misrepresenting the effectiveness of "Geritol" liquid and tablets. The commission ruled that Geritol television com-

Continued




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Forty-acre estate to assure privacy in a restful environment.

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mercials and newspaper advertisements falsely represent that all cases of tiredness, loss of strength, run-down feeling, nervousness and irritability indicate a deficiency of iron and that the common, effective remedy for these symptoms is Geritol.

Geritol is not beneficial except in the small minority of persons whose tiredness symptoms are caused by a deficiency of iron or one or more of the vitamins contained in the preparation, the FTC said.

## CONGRESS ENACTS MOST HEALTH LEGISLATION

More and farther-reaching health legislation was enacted into law this year than ever was acted upon by a previous Congress.

Medicare and the heart disease, cancer and stroke programs topped the list of such legislation enacted into law, but there also were other important new health programs authorized. Several existing ones were expanded.

Approved health legislation included:

—A $787 million aid program for medical, pharmaceutical and other health schools. It authorized for the first time Federal scholarships for students and operating funds for medical schools.

—A $105 million program of aid for medical libraries.

—A $250 million, three-year extension of grants for construction of health research facilities.

—Authorization of strict Federal controls on manufacture and sale of barbiturates and amphetamines.

—Requirement that cigarette packages, beginning Jan. 1, 1966, carry a health hazard warning.

—Extension of the vaccination program and expansion of it to include measles.

—Annual appropriation of a record $1.2 billion for the National Institutes of Health.

—Three new assistant secretaries of Health, Education and Welfare—one for health affairs.

—A four-year, $92.5 million program of aid to municipalities for construction of garbage disposal plants and research in the field.

—Greater Federal powers in the water pollution field and $300 million to help communities build sewage plants.

—New Federal powers to control air pollution, including requirement that new autos have devices to reduce exhaust fumes.

—Expansion of the Federal vocational rehabilitation program, including $300 million in grants for building and initial staffing of rehabilitation facilities and workshops.

—A four-year, $173 million program for initial staffing of community health centers.

—An Administration on Aging in the Health, Education and Welfare Department.

—Appropriation of $157 million for Project Headstart-nursery school training and medical examinations of pre-grammar school children from low-income families.

—A $69 million hospital program for the Appalachia area.

—Automatic rank of lieutenant general or vice admiral for surgeons general of the army, navy and air force.

—Extension for three years of the program of grants for health services for

Continued




The human spine is not engineered fo prolonged sitting at desks, pianos, type writers and drafting boards. The stresse set up by the heavy, forward-tilted hea and trunk, balanced precariously on a insufficient base, result in strain of th dorsal musculature, particularly at th low lumbar level.

*The unusual muscle-relaxant and ana gesic properties of 'Soma'* make it espe cially useful in the treatment of low bac sprains and strains. 'Soma' is widel prescribed ☐ **to relieve pain** ☐ **to rela muscles** ☐ **to restore mobility.**

*Indications:* 'Soma' is useful for management c muscle spasm, pain, and stiffness in a variety c inflammatory, traumatic, and degenerative muscu loskeletal conditions. It also may act to normaliz motor activity in certain neurologic disturbance

*Contraindications:* Allergic or idiosyncratic rea tions to carisoprodol.

*Precautions:* 'Soma', like other central nervou system depressants, should be used with cautic in patients with known propensity for taking e cessive quantities of drugs and in patients wit known sensitivity to compounds of similar chem cal structure, e.g., meprobamate.

*Side Effects:* The only side effect reported with ar frequency is sleepiness, usually on higher tha recommended doses. An occasional patient ma not tolerate carisoprodol because of an individu reaction, such as a sensation of weakness. Oth rarely observed reactions have included dizzines ataxia, tremor, agitation, irritability, headache, i crease in eosinophil count, flushing of face, ar gastrointestinal symptoms.

One instance each of pancytopenia and leuk penia, occurring when carisoprodol was admi istered with other drugs, has been reported, as ha an instance of fixed drug eruption with carisoprod and subsequent cross reaction to meprobamat Rare allergic reactions, usually mild, have include one case each of anaphylactoid reaction with mi shock and angioneurotic edema with respirato difficulty, both reversed with appropriate therap In cases of allergic or hypersensitivity reactior carisoprodol should be discontinued and approp ate therapy initiated. Suicidal attempts may pr duce coma and/or mild shock and respirato depression.

*Dosage:* Usual adult dose is one 350 mg. tabl three times daily and at bedtime.

*Supplied:* Two Strengths: 350 mg. white table and 250 mg. orange, two-piece capsules.

*Before prescribing, consult package circular.*

## for the relief of low back sprains and strain

# SOMA (CARISOPRODOL

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Continued

domestic migrant agricultural workers.

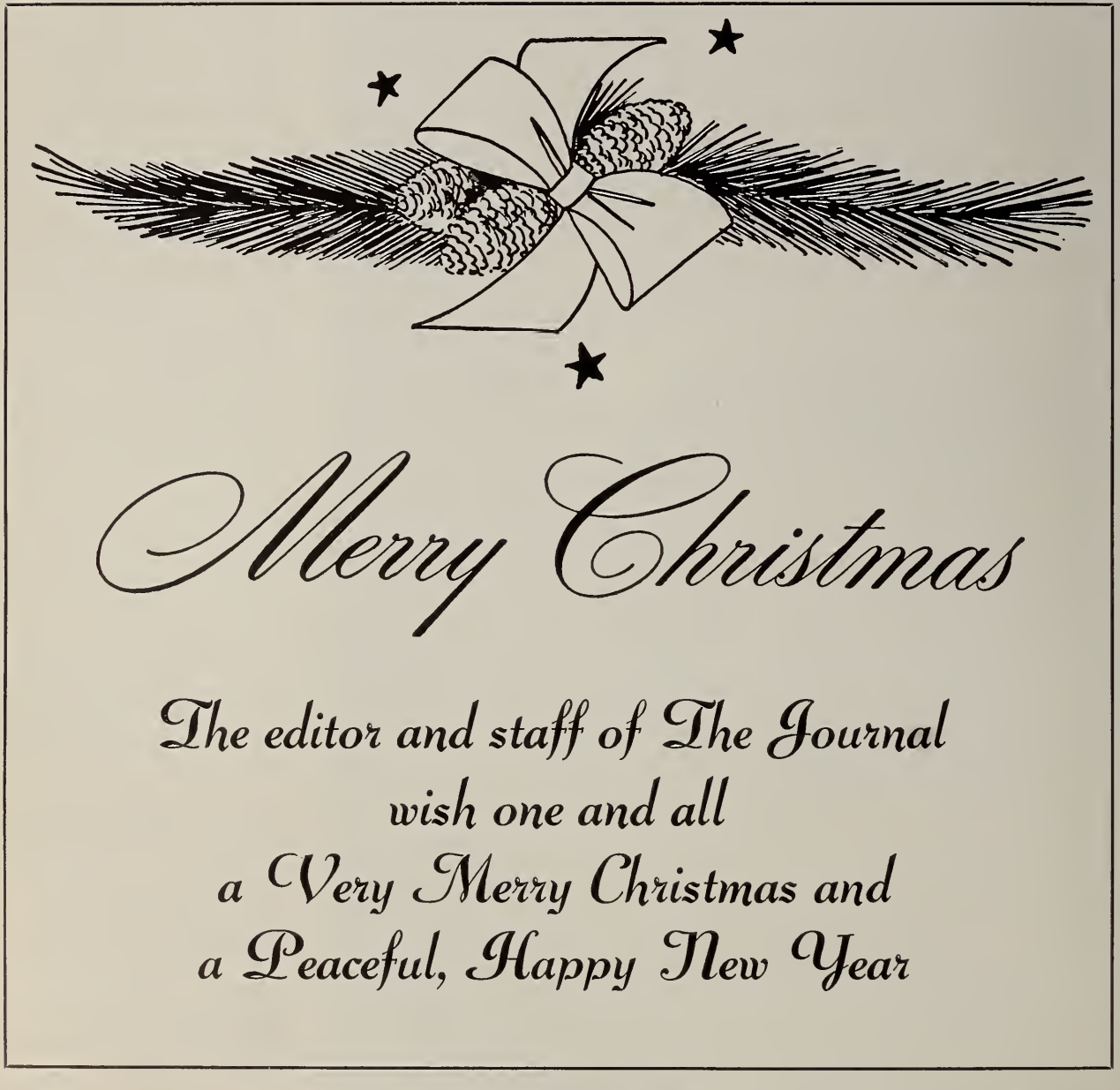
—A one-year extension of the program of grants for general health aid and for community health services.

## COMMUNITY MEASLES VACCINATION PROGRAMS URGED

Community vaccination programs against measles have been recommended by the Surgeon General's Advisory Committee on Immunization.

In extending the Federal vaccination program for polio, diphtheria, tetanus and whooping cough, Congress this year expanded it to include measles.

The committee said that measles is one of the most important causes of serious illness in children and recommended that continuing "maintenance" programs aimed at vaccinating children about one year of age be established in all communities. ◄





*The Pain Is Gone*

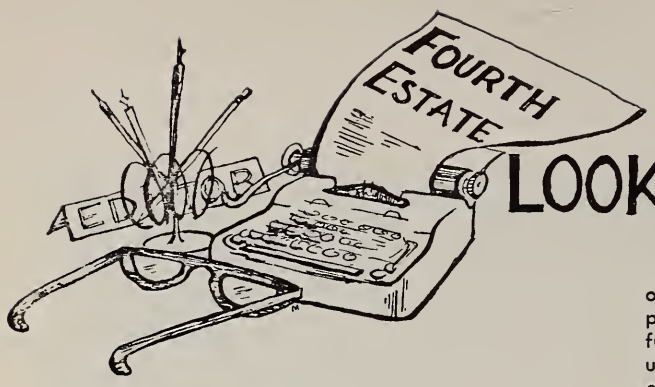
Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

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# LOOKS AT MEDICINE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are of interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

## Well Done

Dr. Joe M. Black, the family doctor from Seymour who served wisely and well as the spokesman for Indiana's physicians this last year, has completed his term as president of the Indiana State Medical Association.

This was a critical year for medicine in Indiana. There were major revisions in the state's licensing laws, a growing debate over the proper course of medical education, and there were the problems of what to do with Medicare.

Dr. Black served, not to conceal these problems, but rather to focus the attention of both physicians and laymen on the issues so calm discussion was first possible and finally successful.

We wish Dr. Black well, both in his practice and in his service to organized medicine. We feel American medicine could do far worse than to choose our family doctor from Seymour as its spokesman.

And we give our best wishes to Dr. Black's successor as president of the state medical society, Dr. Kenneth O. Neumann of Lafayette, another family doctor.—*Indianapolis Star,* Oct. 16, 1965.

## The Doctor Shortage

The proposal of a council of Indiana doctors that the state build new medical schools deserves the most serious consideration.

Indiana has a population fast approaching 5 million. Yet it has only one medical school. The Indiana University School of Medicine admits 200 freshmen a year. Many medical experts think its enrollment is too large. Its admissions are approximately double that of the average medical school.

The experts' concern is based upon the belief that medical education can suffer if the enrollment is too large for the faculty and plant. The idea seems to be that the more students that must be trained, the thinner the faculty must spread its talents and attention. This is a widespread weakness in undergraduate schools, as most postwar college graduates are well aware. Medical education is a field that should not take shortcuts or cut corners.

In spite of the fact that experts think I. U. Medical School is already too large, its administration wants to expand it further. Care must be taken that this excellent school is not force-grown to the point where its administration becomes unwieldy and its teaching inferior.

But the most urgent need from the public's viewpoint is a need for more doctors. A recent study financed by Eli Lilly and Company showed that the nation's population is growing much faster than physicians are being trained to minister to its ills. Unless steps are taken to ward off the eventuality, it said, the nation will experience a serious shortage of doctors within a few years.

The long lines of patients waiting sometimes for hours in so many doctor's offices and hospital corridors would seem to bear this out.

The Council of the Indiana State Medical Association in proposing new medical schools for the state warned that I.U. "cannot train the number of physicians who will be needed in our state in future years."

The time to meet the problem is now — before it reaches the dangerous stage.—*Indianapolis Star,* Oct. 17, 1965.

Continued

## to help relieve pain in common anorectal disorders

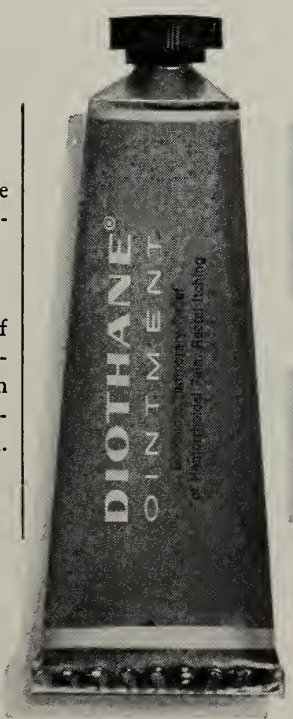
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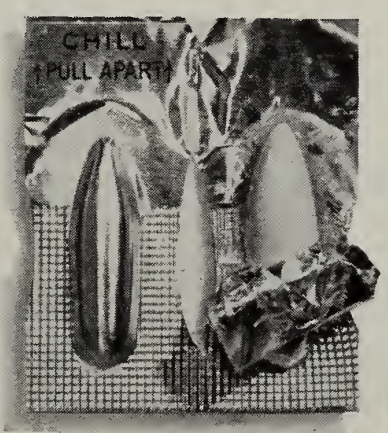
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## FOURTH ESTATE

Continued

### The Destroyers

Social Security pensioners, despite recent increases in benefits, have less buying power today than they had in 1958.

That is the grim reality behind all the talk of government spending programs for poverty, "medicare," and so forth helping the elderly and the indigent. These spending programs have so eroded the value of the dollar that pensioners are now worse off than they were seven years ago.

These facts were recently brought to light by Sen. Jack Miller, R-Iowa, who drew up a table showing the continuing depreciation of the dollar's purchasing power and the consequent reduction in the value of Social Security payments. The table shows the pensioner today has about $10 less in annual buying power than he had in the 1950s:

| Year | Annual Pension | Real Purchasing Power* |
|---|---|---|
| 1940 | $499.20 | $495.20 |
| 1950 | 870.00 | 502.86 |
| 1952 | 930.00 | 486.39 |
| 1954 | 1,062.00 | 549.05 |
| 1958 | 1,140.00 | 548.34 |
| 1965 | 1,219.80 | 539.15 |

Sen. Miller noted that someone who had paid into the Social Security fund since 1940, on an annual salary base of $3,000, has $9.90 less purchasing power now than he would have had, on a lower pension sum, in 1954. Since 1958, his loss of purchasing power has been $9.19.

* In terms of 1939 dollar.



These lugubrious results are the direct product of the deficit spending programs the Liberal administration in Washington says are intended to solve problems of want and hardship. Over the years, these programs have incurred a massive Federal debt, and have pumped new money into the economy without a corresponding increase in production.

The outcome has been inflation, as each dollar is worth less and less in terms of what you can buy with it, and prices continue to climb. This procedure not only visits hardship on those dependent on pensions and annuities. It also leads to increased government controls, as in the Johnson administration's wage-price "guidelines," as government attempts to confine the effects of the inflation it has caused.

In short, the big-spending politicians in Washington who have advertised "something for nothing" have perpetrated a fraud on the people of the United States. Promising to alleviate hardship, they have increased it. And promising to protect Social Security pensioners, they have in fact whittled away the purchasing power of their benefits.—*Indianapolis News*, Oct. 1, 1965.

### Good Evening

**By CLIFFORD B. WARD**

It is likely that some doctors, maybe many of them, will decline to co-operate with the Federal government's "Medicare" law, but it is highly unlikely that any doctor will refuse his services to senior citizens just because he, the doctor, is not co-operating with the new law. I can't conceive of any reputable physician who has had a senior citizen for a patient saying to him, "Get yourself a new doctor." Doctors, for the most part, are not that kind of person.

Doctors are human beings and for the most part better educated, as well as more solicitous for people than the average human being. There are undoubtedly some first class no-goods in the profession, but they are as much disliked in the profession

Continued



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as out of it, and eventually these no-goods come acropper.

Medical groups are constantly striving to police their own ranks, and through their grievance committees investigate all complaints that they receive.

If you really believe you did not get a square deal from some doctor, report him to the grievance committee of the medical society, but don't believe everything you hear about some doctor neglecting a patient or overcharging him.

### Labeling the Unethical

People do like to exaggerate and facts are sometimes at great variance with wild stories that people tell. Sometimes, undoubtedly, some of these wild stories are true, but no one will get more excited about them than the grievance committee of a medical society. Any doctor who would refuse to treat an aging patient of his simply because he was not co-operating with medicare would be adjudged an unethical doctor in any medical league. A doctor has a right not to co-operate with medicare, although most doctors will. Those doctors who do not co-operate will continue to practice medicine, however, and not bar aiding the aged.



Doctors have taken an unnecessary public relations beating in recent years, some of it being their own fault and some of it being the fault of loose talk and by medicare advocates. They don't actually rate the criticism they get. When they do, it is often the fault of not only themselves, but their wives as well. They want to get rich quick. Not all doctors are overworked, but most of them are. If they wish to get a few of the ordinary extras out of life, it is understandable.

Very few laymen have the same deep-seated regard for the value of a human being as dedicated doctors. They are not always right and they seldom are perfect, but sickness and suffering gets under their hides faster than it does under the hides of most laymen. They want to get paid, an idea with which no one can quarrel.

### When to Complain

They have to eat also, and where some doctor or his nurses get too enthusiastic about charges, it's worth a complaint. But my own experience with doctors over the years has been very good. I have never had anything but a high regard for the profession, simply because some of the finest men I have known are included in it.

My only beef with the profession has been occasioned by some silly characters in it, and their wives, who went out of their way to acquire a silly social status with high-priced cars, high-priced homes, high-priced minks, and then to advertise their extravagances in every way they could. There are a lot of persons in the world who do not make much money and naturally they resent unnecessary shows of extravagance by doctors treating them.

Doctors in their legitimate quarrel with medicare should make it plain, if making it plain is necessary, that their aging patients are not going to be thrown out in the cold as a result of any quarrel with medicare. And the aging should themselves relax and not start worrying about things that in all probability are not going to happen—Reprinted with permission from the *Fort Wayne News Sentinel,* Oct. 5, 1965. ◄

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# Brain Scanning With Radioisotopes for Diagnosis of Intracranial Lesions

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Indianapolis*

EARLY and accurate detection of intracranial space-occupying lesions usually requires a combination of diagnostic methods. The patient's history and neurological examination ordinarily directs attention to the presence of an intracranial disorder. Plain skull radiographs may be of localizing value and more often may indicate signs of increased intracranial pressure. The electroencephalogram is a valuable, non-traumatic screening test, but nonspecific dysrhythmias or non-localizing recordings are frequent.

The neuroradiological contrast procedures —cerebral angiography, pneumoencephalography and ventriculography—when variously combined, successfully detect over 90% of intracranial mass lesions. However, the precise localization is not as well demonstrated by contrast studies, since they usually portray only indirect signs of a mass lesion. It is also generally recognized that these procedures are painful, time-consuming, at times technically difficult to perform and are accompanied by a low but significant incidence of serious complication.

* From the Department of Radiology and the Section of Neurological Surgery, Indiana University Medical Center, Indianapolis.
Dr. Dehner is currently at 4500 U.S.A.F. Hospital, Langley A.F.B., Virginia.

Brain scanning with radioactive materials has become increasingly popular in many hospitals across the country as an additional neurodiagnostic method. The major advantages of this test are its safety, ease of application and reliability. The development of commercially available, automatic photoscanning systems at reasonable cost is an important factor in the more widespread use of this method.

This article reviews the basic concepts of brain scanning with radioisotopes, and presents our results in 67 patients who were scanned during the first year of its use at the Indiana University Medical Center.

## Rationale

In brain scanning, after a radioactive material is injected intravenously, the radioactive emissions from the head are measured by a suitable instrument and a pictorial record (the scan) is made simultaneously. The brain is particularly well-suited for scanning because of the blood-brain-barrier phenomenon. This permits only a gradual and selective passage of many compounds from the blood into the brain parenchyma. Thus, under normal conditions, the radioactive uptake shown on the scan in the intact brain is considerably lower than the uptake in surrounding tissues which have a richer vascular supply,

such as the scalp, face, pharynx and occipital muscles.

When an intracranial tumor or other focal abnormality causes a breakdown in the integrity of the blood-brain-barrier, the radioactive substance localizes in the area of tissue destruction. The lesion thus stands out as an area of increased activity in sharp contrast to the lower levels of activity in the intact brain. Increased local vascularity present in some lesions contributes to the higher activity recorded over the abnormal site.

### Historical Development

The detection of space-occupying lesions of the brain with radioactive materials dates back to the work of Moore.[1] In 1948 it was known that fluorescein dye given preoperatively would concentrate in brain tumors, so that at surgery the extent of the lesion could be estimated with the aid of an ultraviolet light. The next logical step for Moore was to tag fluorescein with I-131, a gamma-ray emitting isotope. The rays could be detected and counted by means of a Geiger-Muller tube held on the scalp before surgery.

By counting corresponding sites over both sides of the head, one could determine with some accuracy where the tumor was located by the variation in count rate. Improvements in shielding and collimation of the detector followed, and standard counting points on the scalp were established. Some used multiple Geiger-Muller tubes simultaneously or elaborate statistical methods to help determine the site of abnormality. The introduction of I-131 tagged human serum albumin (RISA) in 1951 reduced the radiation dose to the patient and resulted in better localization because of higher concentration of this agent within the lesion.

Using these initial, time-consuming methods, early reports of success with brain scanning were variable, ranging from five to 95% accuracy in localizing intracranial lesions. Davis and Ashkenazy[2] first reported 90% accuracy in localizing space-occupying lesions, but lowered their figures in a larger follow-up series. At the other extreme, a report from England in 1952 indicated only five percent correct localization of brain tumors in their experience with 20 cases.[3] Peyton and co-workers[4] localized 70% of tumors by careful application of the method; Dunbar and Ray[5] reported a 76% success rate with 30 tumor cases in 1954. Such factors as equipment, technic, isotope used, method of data analysis and interest and enthusiasm (or lack of it) all contributed to the variable results with the early methods.

Another approach to radioisotope localization of intracranial lesions was the use of positron-emitting isotopes (Arsenic-74 and Copper-64). This technic permitted the detection of an abnormal isotopic concentration within the skull at any depth with equal sensitivity, and was one of the first to incorporate the concept of rectilinear scanning of the head with an automatic apparatus to replace manual counting methods. Sweet, et al.[6] reported 80% success in localization of brain tumors using Arsenic-74. The major disadvantages of the method were the inherent complexity and high cost of the scanner, the increased radiation dose to the patient and the high cost of the isotopes.

In the past eight years, there have been many improvements in the detecting equipment for gamma-emitting isotopes. The major advances have been: (1) the scintillation counter, a much more sensitive instrument to detect gamma rays than the Geiger-Muller tube; (2) improved shielding and focused collimation to enhance the resolving power of the detector; (3) automatic scanning, which results in a uniform survey of the head, and (4) a photographic method of recording the radioactive distribution (the photoscan), in addition to the usual solenoid paper recording (dot scan).

The photoscan enhances small differences in activity and is recorded on regular x-ray film. Today there are several fully-automatic scanners which incorporate all of these improvements. These instruments are capable of producing remarkable pictorial recordings of the organ being scanned, and operation of this equipment by technical personnel is relatively simple. The initial cost is relatively modest when one considers that the same instrument can

be used for scanning many other organs (thyroid, liver, kidney, spleen, etc.).

Radioactive Mercury-203 tagged to Neohydrin (chlormerodrin) was introduced in 1959, and immediately became popular for brain scanning because of the decreased whole body dose and claims of improved visualization of a focal lesion.[7] This isotope is cleared from the bloodstream more rapidly, and scanning can be done much earlier (2-6 hours) than with RISA (24-48 hours), which is a major practical advantage.

## Technic

The radioisotopes which have been used at the Indiana University Medical Center are RISA and Hg-203 Neohydrin. Whenever possible, a 1 cc. dose of stable Mercuhydrin is given intramuscularly 24 hours before performing the Mercury scan. Lugol's solution, ten drops orally t.i.d. is given before the RISA scan and continued for three days. These preparatory medications have a blocking action on the kidneys and thyroid respectively, to decrease the radiation dose to these organs. On the day of the scan the patient is given 10 microcuries/Kg. Hg-203 Neohydrin intravenously up to a limit of 700 microcuries; the scans are performed approximately four hours after injection. For RISA scanning, the patient is given 5.5 microcuries/Kg. RISA intravenously and scans are done in 24 and 48 hours.

Brain scans are performed here using an automatic scanner* with a 3″ x 2″ sodium iodide crystal and a 19 hole focusing collimator. A solenoid paper "dot-scan" and a photoscan on regular x-ray film are obtained simultaneously. Typical control settings are: Scan speed 28 cm/min; line spacing 0.4 cm; time constant ⅛ second; dot factor 2; density 100; count per minute differential 30; analyzer window 314 to 414 (RISA) and 229 to 329 (Mercury); CRT voltage set to give maximum density at maximum count rate; background cutoff set to exclude minimum count rate. The maximum count rate is selected over the nasion unless a focus of greater activity is located over the brain by manual movement of the detector before the AP scan is begun.

The head is routinely scanned in the AP and lateral positions, using a "flexicast" to immobilize the head. The AP scan is performed first, and care must be taken to tuck in the chin to make the cantho-meatal line perpendicular to the table top. The lateral scan is then carried out with the side of the suspected lesion or the side showing an abnormality on the AP scan nearest the detector. A PA scan is done when indicated. Each scan takes 25-30 minutes, or slightly over one hour for the routine procedure. The nasion, supraorbital ridges, external canthus of the eye and external auditory canal are marked as fixed landmarks at the start of each scan.

We have compared Mercury and RISA scans in a number of patients on whom both types were performed, and the results were essentially identical.[8] Therefore, it is our present policy that scanning with Hg-203 Neohydrin is usually done first, and the test is completed within five hours. If the results are equivocal, scanning with RISA at 24 and 48 hours is then carried out.

## Results

There were 167 brain scans performed on 67 patients during the first year photoscanning was used at the Indiana University Medical Center. All scans were interpreted by the authors in random order as unknowns, with names covered and no clinical history available. Each scan was placed into one of three categories:

*Positive*—a definite focal abnormality is present

*Equivocal*—a small, questionable focal area, or diffuse patchy pattern of increased activity is present

*Negative*—no abnormal activity is present

Only one case had to be excluded from this review because of technical problems resulting in inadequate scans. The summary of results in this group of patients is seen in Table 1.

### *Tumors*

There were 25 patients with proven neoplasms—23 verified histologically and two proven unequivocally by radiographic studies. The tumors were correctly localized

* Picker Magnascanner, Picker X-Ray Corporation, White Plains, N. Y.

SUMMARY OF RESULTS WITH 67 PATIENTS—FROM JULY, 1962, TO JUNE, 1963

| Tumors (25) | Positive | Equivocal | Negative |
|---|---|---|---|
| Glioblastoma | 10 | | |
| Astrocytoma | 1 | 1 | 1 |
| Oligodendroglioma | 1 | | |
| Sarcoma | 1 | | |
| Papilloma, choroid plexus | | | 1 |
| Meningioma | 2 | | |
| Metastatic | 5 | 1 | 1 |
| | 20 (80%) | 2 | 3 |
| Intracranial Hematomas and Abscesses (10) | | | |
| Epidural or Subdural Hematoma | 5 | 1 | 2 |
| Abscesses | 2 | | |
| Brain Tumor Suspects (8) | | | |
| Clinically positive | 1 | 2 | 1 |
| Clinically negative | | | 4 |
| Miscellaneous—no tumor (24) | | | |
| Vascular, psychiatric, epilepsy and neuralgias | 0 | 1 | 23 |

TABLE 1

in 20 of the 25 cases (80%). There were 49 individual scans in these 20 patients, and in every case the interpretation was positive. In almost every case the scan abnormality was a large spherical lesion in both the lateral and frontal planes and was vividly demonstrated. All 10 glioblastomas and both meningiomas were accurately localized; a sarcoma of the posterior fossa, an oligodendroglioma and one of the three astrocytomas were demonstrated along with five of the seven metastatic tumors. In the five patients whose scans were not positive, two were equivocal and three were negative. The smaller and more slowly growing tumors, as expected, were in this group.

After reviewing the scans a second time with the final diagnosis known, only one tumor in the equivocal group could be reclassified as positive. In all others the blind reading was as informative as the retrospective interpretation. The following brief reports are illustrative of the value of the brain scan in diagnosis and management of patients with brain tumors.

*Case #1*

A 41-year-old woman was a brain tumor suspect since 1950, at which time a craniotomy was done but no tumor was found. A temporal lobe biopsy was negative. Intermittent symptoms of headache, drowsiness and confusion continued through the years and became worse in 1962. Skull radiographs were negative. A RISA brain scan (Figure 1) demonstrated a large spherical lesion adjacent to the sphenoid ridge. Angiography was compatible with a meningioma of the sphenoid ridge, which was confirmed at surgery.

*Case #2*

A 53-year-old man had had a glioblastoma of the right frontal lobe, partially excised one year before. Radiation therapy was given after surgery. He was admitted this time because of symptoms of increasing intracranial pressure. The angiogram was difficult to interpret, as there was stretching of the anterior cerebral vessels which were shifted to the right, toward the site of the original tumor. No tumor stain was visible. The brain scan (Figure 2) revealed an extremely large recurrent tumor in both frontal lobes, which was subsequently verified at autopsy.

*Case #3*

A 30-year-old man had had a primary sarcoma of the cerebellum removed in 1962. About one year later he was readmitted becaused of vomiting and disorientation leading to a semi-comatose state. Several neuro-

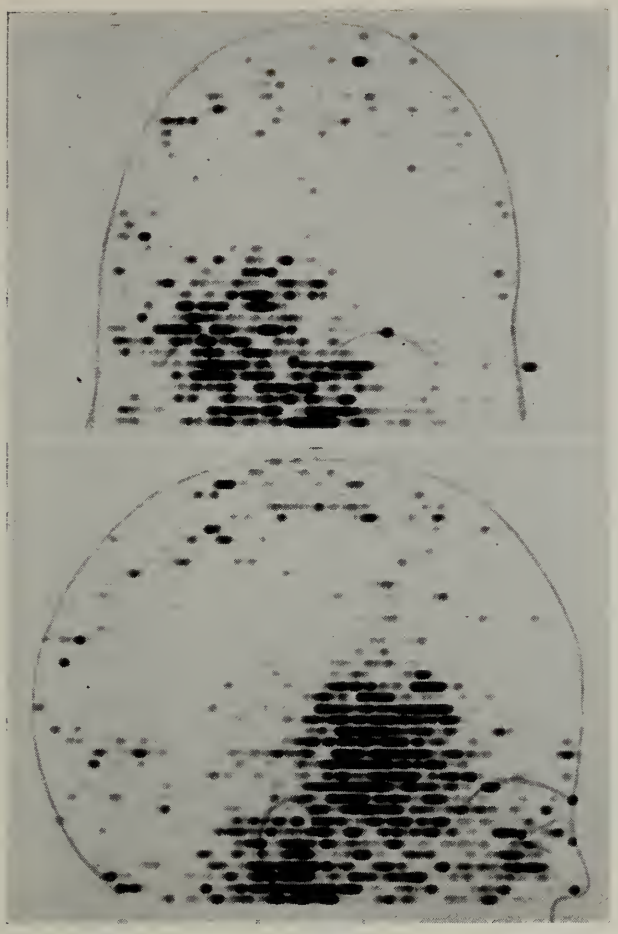


FIGURE 1
ANTEROPOSTERIOR and lateral brain scans showing abnormal uptake of RISA at 48 hours in a sphenoid ridge meningioma, (Case #1).

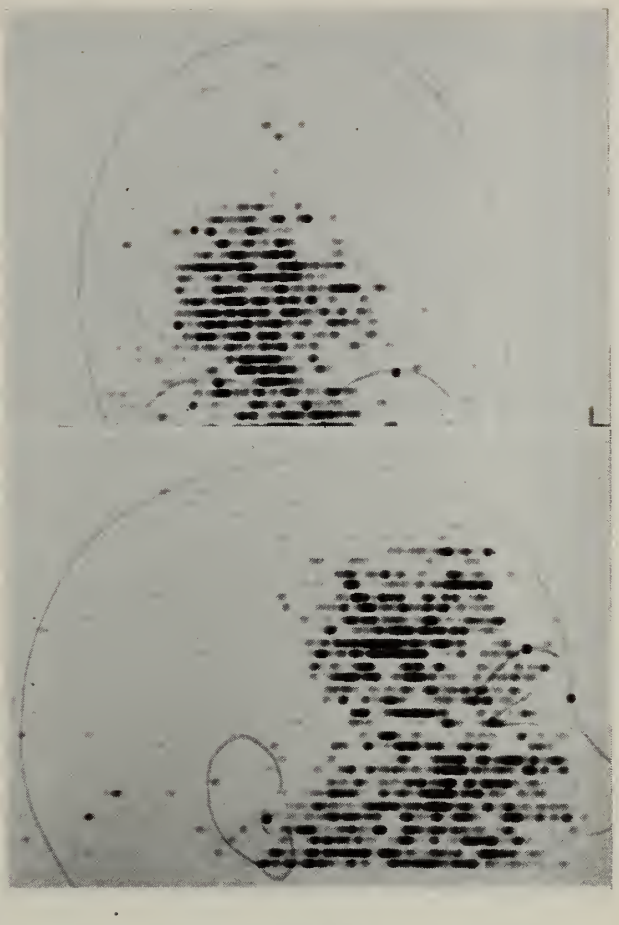


FIGURE 2
ANTEROPOSTERIOR and lateral scans which show abnormal concentration of RISA at 48 hours in a transcallosal glioblastoma, (Case #2).

radiologic procedures including positive contrast ventriculography failed to confirm the suspicion of a recurrent neoplasm. The lateral and PA brain scans revealed a definite focal abnormality in the posterior fossa which was consistent with recurrent tumor (Figure 3A). A full course of radiotherapy was given, with 6000 rads tumor dose delivered to the posterior fossa. The clinical response was excellent, and the patient was doing well more than a year later. On repeat scan after completion of radiotherapy, the abnormal focus in the posterior fossa disappeared (Figure 3B).

*Intracranial Hematomas and Abscesses*

There were eight patients with abnormal collections of blood in the subdural or epidural space. The positive scans characteristically showed a crescent-shaped increase in activity over the convexity of the brain on the AP scans, with poorer localization on the lateral scans. This is the typical configuration of a subdural abnormality and is generally not confused with a neoplasm. One patient with a focal abnormality in the occipital lobe was found to have a chronic brain abscess at surgery. Another patient had an abscess mainly confined to the subdural space, and the scan showed dense activity surrounding the cerebral hemisphere on the AP scan.

*Case #4*

A 41-year-old man had a sudden onset of headache, weakness and staggering. A mercury brain scan (Figure 4) revealed a crescent-shaped increase in activity over the right convexity of the brain on the AP scan, typical for a subdural hematoma. Angiography showed displacement of vessels from the skull, and a chronic subdural hematoma was removed at surgery. On follow-up scans during the succeeding year there was very slow conversion back to normal appearance.

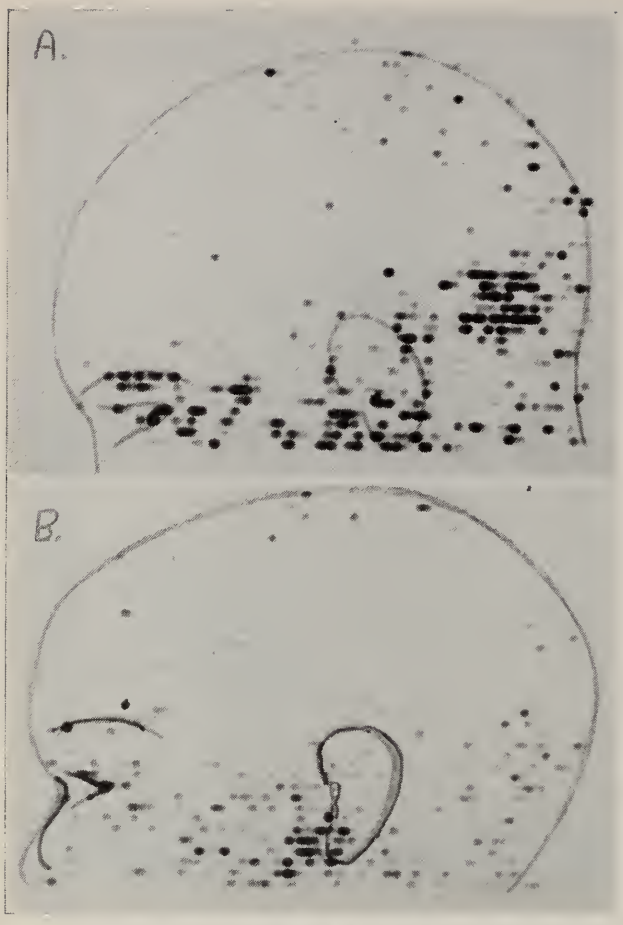



FIGURE 3
SERIAL lateral scans with Hg-203 Neohydrin demonstrating a recurrent cerebellar sarcoma (A); after radiotherapy the abnormal focus is no longer present (B), (Case #3).



FIGURE 4
ANTEROPOSTERIOR and lateral scans with Hg-203 Neohydrin which show increased activity over the right convexity of the head on the AP scan corresponding to the location of a subdural hematoma, (Case #4).

*Brain Tumor Suspects*

Four of the eight patients in this group had known primary tumors elsewhere in the body, and had negative brain scans. Extensive clinical and radiographic work-ups for metastatic disease failed to show any evidence of a brain metastasis; appropriate therapy for the primary tumor was carried out.

Metastatic disease was strongly suspected in two other patients, but further radiographic studies were not carried out. One scan was positive and the other equivocal. Primary tumors were suspected in two other patients, but a final diagnosis has not yet been made.

*Miscellaneous—No Tumor*

There were 24 patients in this group who had a total of 51 scans. Nine had vascular problems—small aneurysms, cerebrovascular insufficiency, hypertensive encephalopathy, and "strokes." Four patients with epilepsy or psychiatric problems and six with craniofacial neuralgias were also scanned. There were no positive scans in this group. There has been a one year follow-up on these patients, and none of them has been found to have an intracranial tumor.

## Comment

Brain scanning with radioactive materials has found its greatest usefulness in the diagnosis and localization of intracranial tumors. The procedure currently gives an overall diagnostic accuracy of 65-93%, according to reports which include intracranial tumors of all types.[9-13] This success compares favorably with the accuracy of other neurodiagnostic procedures: angiography (75%), pneumoencephalography (80%), and ventriculography (90%). In a study of 115 patients, DiChiro[10] reported a correct localization of tumors by scanning alone in 83%, and with a combina-

tion of neuroradiologic contrast studies in 92%. The percentage of intracranial tumors correctly localized by scanning is consistently higher than found by electroencephalography.

The type, size and location of a tumor are important factors in the successful localization with brain scanning. The more anaplastic and richly vascular tumors, i.e., the glioblastomas and meningiomas, are nearly always demonstrated. The accuracy rate for these tumors in our group was 100%—all ten glioblastomas and both meningiomas. The rate of success in other large series for these two common types of tumors ranges from 90 to 100%.

The slower growing, poorly vascular tumors such as astrocytomas and oligodendrogliomas with less affinity for the radioactive material are more difficult to detect. Metastatic lesions are usually localized if they are large enough. A focal abnormality must be at least 2 cm. in size if it is to be detected by present scanning equipment. Of course, size is a critical factor in other diagnostic studies also. The location of the tumor is a third important factor. A lesion adjacent to the areas of higher activity at the base or vertex of the skull is more difficult to see, and posterior fossa lesions are sometimes obscured by overlying muscle. Intrasellar lesions are generally not demonstrated but a suprasellar tumor can be seen.

The localization of a tumor by conventional neuroradiologic studies is often by indirect signs—by observing displacement of the contrast-filled vessels or the air-filled ventricles. The lesion is directly visualized as a tumor stain or an intraventricular mass only in a minority of cases. On the other hand, the abnormal concentration on the brain scan is a direct representation of the intracranial location of the tumor, and this localization is often more precise than by contrast studies. The size and extent of the tumor may also be more directly appreciated.

This information can be of value to the neurosurgeon in planning the position of the cranial bone flap and the procedure to be used. Also, the radiotherapist may use the brain scan to plan the position of the treatment ports, and to evaluate the tumor response after therapy has been given. Rarely is the scan the only positive test in the work-up of a tumor suspect (see Case 3). Occasionally, a definite lesion is detected by scanning while contrast studies are equivocal or show only subtle changes suggestive of a neoplasm. The brain scan is of special value in the problem of recurrent tumor after surgery, when the normal anatomy has been altered.

Evidence as to the type of tumor is sometimes best demonstrated by contrast studies, which cannot be done by a brain scan. There are many other abnormalities of the brain and cerebral vessels which are best diagnosed by contrast studies and electroencephalography, such as vascular occlusions and aneurysms, congenital malformations, pituitary lesions and epilepsy. Therefore, the brain scan complements these other studies and serves as a preliminary screening test, particularly in the evaluation of brain tumor suspects. A focal lesion on the brain scan does not always indicate the presence of a neoplasm. In our series a brain abscess and a localized epidural hematoma had the appearance of a focal lesion.

All patients in our group with positive scans had surgical lesions. The accuracy rate in our group of 25 patients with proven brain tumors was 80%. There were no "false-positive" scans in the miscellaneous group of 24 patients without focal abnormalities. The combination of a very low false-positive rate and a high detection accuracy for surgical lesions makes brain scanning a good screening method for brain tumor suspects, especially those with minor signs or symptoms upon whom one would hesitate to do contrast studies.

Finally, the brain scan is safe and painless for the patient, as contrasted with other neuroradiologic studies. Only a venipuncture is needed to inject the isotope. The scanning takes about one hour and is commonly done on an outpatient basis. It can be carried out quite satisfactorily on comatose patients when necessary; agitated patients may be sedated. No complications of brain scanning have been reported.

The whole body dose from a RISA scan is about 0.7 rads and from a Mercury scan

about 0.3 rads[7]; this is not a significant radiation hazard considering the usefulness of the test. There is no hesitancy to do multiple scans on a patient when indicated. Any amount of radiation given to children is considered a hazard and, therefore, the indications are more strict. Newer radioisotopes for brain scanning which further reduce the radiation dose are undergoing evaluation. Hg-197 Neohydrin has been reported[14] to produce adequate scans while decreasing the whole body and renal dose, but is more difficult to utilize for routine use because of its short half-life.

## Summary

Our first year's experience with brain scanning using radioisotopes in 67 patients has been analyzed. There were 25 patients with verified tumors of the brain, both primary and metastatic. A positive scan was found in 20 (80%) and in almost every case, the lesion was vividly demonstrated. Other positive scans were found with subdural and epidural hematomas and intracranial abscesses. The characteristic configuration of a subdural hematoma on the scans has been noted. In a group of 24 patients with a variety of non-neoplastic conditions, there were no positive scans.

The high rate of accurate tumor detection and the very low false-positive rate make brain scanning a valuable screening test for brain tumor suspects. A positive, focal abnormality on the scan usually, but not always, indicates a neoplasm. Scanning is considered complementary rather than supplementary with respect to other methods of diagnosis, since many other intracranial conditions are best demonstrated by contrast studies, skull radiographs, or the EEG. The more precise localization of a tumor by scanning is of value to the neurosurgeon and the radiotherapist.

Brain scanning is relatively simple to perform and is safe and painless for the patient. The test is not objectionable because of cost or radiation hazard. Further improvements in equipment and radioisotopes are to be expected in this rapidly expanding field.

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Case Report and

Brief Review of the Literature

# *Bronchopulmonary Geotrichosis*

*WILLIAM K. NASSER, M.D.*
*WALTER J. DALY, M.D.*
*Indianapolis**

BRONCHOPULMONARY infection due to the Geotrichum fungus is considered a comparatively rare disease in the United States and European countries. According to Dodge,[1] Geotrichum is a subspecies of Eremnascacea imperfecta, and was first described by Link in 1809. Only a limited number of cases have been reported since the disease was first recognized. The present case was seen at the Indiana University Medical Center in February, 1963.

## Case Report

The patient, a 38-year-old white, married housewife, was admitted from the outpatient clinic for evaluation of an abnormal chest x-ray and high blood pressure. She had had severe morning headaches and a nonproductive cough of approximately six months duration.

She had been told she had high blood pressure 16 years earlier, following her second pregnancy. Although her appetite had remained very good, she reported a weight loss of 49 pounds over the past six years, 12 of which had been lost in the year just preceding this admission. She denied night sweats, chills, fever, orthopnea, ankle edema or chest pain, but had noticed some slight dyspnea on exertion.

*Physical examination*: Blood pressure was 200/120 in both arms. The patient was emaciated and there were tubular breath sounds in both apical regions. The remainder of the physical examination was normal.

*Laboratory findings*: Hemoglobin was 12.8 gm. per 100 milliliters; white blood count was 5250 per cubic milliliter. Urinary colony count was 100,000 bacteria per milliliter; Alcaligenes was cultured from the urine. Blood sugar and blood urea nitrogen tests were normal.

*Roentgenologic findings*: Chest x-ray showed a soft nodular infiltrate involving both upper lung fields (Figure 1). Bilateral apical planigrams revealed multiple thin-walled cavities in both apices (Figure 2).

*Hospital course*: It was first felt that this patient probably had pulmonary tuberculosis. However, first, intermediate, and second-strength tuberculin, histoplasmin, coccidioidin and blastomycin skin tests were all negative. At no time were acid-fast bacilli seen or cultured from sputum, gastric washings or urine and no malignant cells were found in her sputum.

Approximately two weeks after admission, a species of Geotrichum was identified from three separate sputum cultures. The identity of this organism was later confirmed by the Indiana State Board of Health



FIGURE 1
CHEST x-ray showing a soft nodular infiltrate involving both upper lung fields.

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Dr. Daly is Assistant Professor of Medicine.

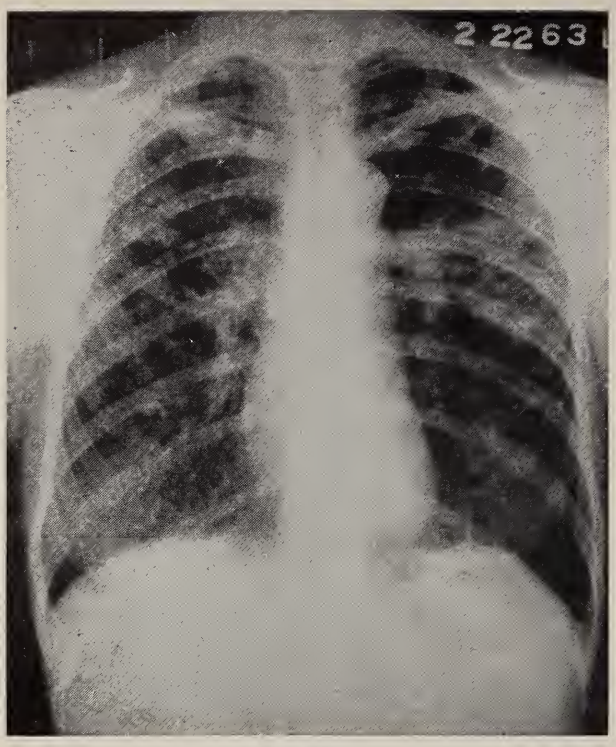



**FIGURE 2**
**BILATERAL apical planigrams revealing multiple thin-walled cavities in both apices.**

and the United States Public Health Service, Communicable Disease Center, Chamblee, Georgia, as Geotrichum candidum. Following the demonstration of Geotrichum in the sputum, the patient was given potassium iodide, 10 drops in water three times daily, and intravenous sodium iodide, 1 gram daily. Over the next three weeks she was eating well, had gained approximately seven pounds, and stopped coughing. However, subsequent chest x-rays did not change. Her hypertension was treated with sedation and guanethidine sulfate (Ismelin).

Following discharge from the hospital, she was seen in the outpatient chest clinic. Her weight had increased from 108 pounds to 123 pounds; she was afebrile and asymptomatic. Sputum cultures again failed to reveal acid-fast bacilli although Geotrichum candidum was again cultured. A chest x-ray showed on change. The patient was last seen in July, 1963. She subsequently moved to a different community and was lost to follow-up.

*Conclusions*: Although Geotrichum is occasionally found in the normal tracheobronchial flora, we feel that the negative tuberculin, histoplasmin, coccidioidin and blastomycin skin tests; absence of malignant cells, acid-fast bacilli and other fungi in the sputum; persistently positive sputum cultures of Geotrichum candidum; elimination of other possible etiologic factors and clinical response to iodides (weight gain and decreased cough), warrant the diagnosis of bronchopulmonary geotrichosis.

## Discussion

Geotrichosis is an infection due to one or more species of Geotrichum, a fungus capable of producing lesions in the mouth, gastrointestinal tract, bronchi or lungs. Geotrichum candidum is frequently isolated from the sputum, skin and feces of patients without clinical disease. A diagnosis of geotrichosis, like that of candidiasis, is justified only by repeated demonstration of the fungus in direct smears and cultures and the exclusion of other possible etiologic agents. In fact, Schnoor[2] cultured Geotrichum in 29% of the 314 stool specimens obtained from medical students, nurses and patients without gastrointestinal symptoms.

In 1934, Smith[3] described five cases of bronchopulmonary geotrichosis which responded to oral iodides. In 1946, Kunstadter, Pengergrass and Schubert[4] reported pulmonary geotrichosis in a patient with bilateral infiltrates, weight loss and constitutional symptoms, who showed complete roentgenologic clearing following iodide therapy. In 1950, two cases of pulmonary geotrichosis in children were reported.[5]

In each, the diagnosis was based upon the clinical course, characteristic sputum, roentgenologic findings of pulmonary infiltrates with hilar adenopathy, positive skin reactions to Geotrichum and negative reactions to tuberculin, coccidioidin and histoplasmin. Although Geotrichum was not cultured from the sputa, the response to oral iodides, positive Geotrichum skin tests and elimination of other possible etiologic factors lead the authors to report these cases as bronchopulmonary geotrichosis.

Among 79 cases of bronchomycoses in the southern United States, two cases of geotrichosis resembling chronic pulmonary tuberculosis were discovered in 1941 by Reeves.[6] In 1952, Bendove and Ashe[7] reported a case of mycethemia due to Geotrichum in a 79-year-old diabetic man who re-

sponded to Neomycin. In the same year Kaliski, Beene and Mattman[8] reported a case of miliary tuberculosis complicated by Geotrichum septicemia in a two-month-old Latin American infant. In 1959, Webster[9] reported three cases of bronchial geotrichosis complicated by pulmonary tuberculosis, Friedländer's pneumonia and pulmonary emphysema, respectively. A fourth case revealed pulmonary cavitation with Geotrichum septicemia. In 1962, Bell, Brodie and Henderson[10] reported a case of pulmonary geotrichosis in a fisherman who responded clinically to Nystatin although the sputa remained positive for Geotrichum.

*Mycology*: Geotrichum candidum is a yeast-like fungus which reproduces, in culture, by segmentation of the hyphae into arthrospores. The organism grows readily at room temperature and at 37° C; can be cultured from sputum on Sabouraud's media and is identified by the rectangular conidia. The organism may be confused with Blastomyces dermatitidis on examination of direct smear without the aid of cultural studies. Thjölta and Urdal[11] have given an excellent description of the morphologic and growth characteristics of Geotrichum in their study which revealed growth of the organism in the sputa of five of eight members of the same family. Two of these eight patients had x-rays that suggested pulmonary tuberculosis, but all eight had negative tuberculin reactions and acid-fast bacilli were not found in any of their sputa.

*Clinical Manifestations*: The clinical manifestations of bronchopulmonary geotrichosis are variable. They may mimic chronic bacterial bronchitis; e.g., cough, hemoptysis, repeated pulmonary infections and rales or the pulmonary form may simulate tuberculosis. These patients may complain of dyspnea, chest pain, night sweats, weight loss, fever, chills, rapid pulse, etc. Smith[3] states that patients with clinical symptoms of chronic bronchitis or pulmonary tuberculosis who have white, mucoid sputum containing "grayish flakes" should be suspected of having an infection with yeast-like or mold-like fungi.

*X-ray*: The roentgenogram may reveal diffuse peribronchial thickening in the bronchial form, show smooth, dense patches of thin-walled cavities in the pulmonary form or be normal. There is nothing characteristic about an x-ray that allows a diagnosis of bronchopulmonary geotrichosis without cultural proof. The roentgen findings may be confused with tuberculosis, sarcoidosis, bacterial infection of the lungs, neoplasm, or certain other mycotic infections—particularly histoplasmosis, coccidioidomycosis, blastomycosis, candidiasis and cryptococcosis. In fact, Geotrichum may be a secondary invader in pulmonary tuberculosis[8] or Friedländer's pneumonia.[9,12]

*Prognosis*: The prognosis for bronchial and pulmonary geotrichosis, in the absence of a concomitant disease or complication; e.g., Friedländer's pneumonia, miliary tuberculosis, septicemia or other debilitating illnesses, is usually excellent and the disease may terminate without therapy.[12]

*Treatment*: The treatment of both bronchial and pulmonary forms should include bed rest, avoidance of overexertion and fatigue, vitamins and a high caloric diet. Iodides are usually considered the agent of choice[3-5,9,12,13] in the oral form as saturated solution of potassium iodide or intravenously as sodium iodide. Others have used Nystatin[10] or Neomycin[7] with successful results. Smith[12] favors the use of an autogenous vaccine along with amphotericin when the above measures have failed to yield a successful clinical response.

## Summary

A case of bronchopulmonary geotrichosis in a young housewife responding clinically but not radiographically to iodides is presented and a brief review of the English literature on this subject is discussed.

Geotrichum is isolated occasionally from the sputum, skin and feces of patients without clinical disease. A diagnosis of geotrichosis, like that of candidiasis, is justified only by repeated demonstration of the fungus in culture and the exclusion of other possible etiologic agents.

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## From *The Journal* 50 Years Ago

The use of local anesthesia is on its way to popularity now because of the discovery in 1905 of novocain by Einhorn. This drug when combined with adrenalin is non-toxic in amounts necessary for most operations. Reports of various clinics show that a large percent of all operations have been done under local anesthetic. At Heidelberg it reached 52%.

The indications for hypodermic anesthesia are as broad as surgery, and every case should be considered favorable for its use unless proved otherwise. Like any other remedy or method of procedure, its success depends upon a proper selection of cases. Children that are too young to understand what is going on, or adults who will not understand must be denied this blessing, for it is easy to understand that the effects of fright might be worse than those of a general anesthetic.

* * * *

The technic when operating with local anesthesia alone must be more painstaking than usual. The ability of the patient to feel and speak make a sure guide as to when the injections have been thorough. The knife cut seems to give no pain. Scissor cuts, blunt dissection, heavy handed sponging and sudden pulling may cause some reflex surprise and it is to guard against these unpleasant sensations that requires more patience and time on the part of the operator than when the patient is asleep. That the results are worth the extra effort, anyone who has experienced them will testify . . . . Charles O. Bechtol, M.D., "Local Anesthesia in Major Surgery," *JISMA*, December, 1915.



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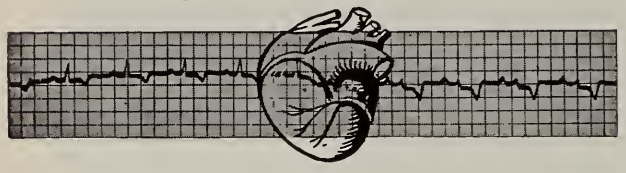
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# Electrocardiogram of the month



*Presented as a regular feature of The JOURNAL, Electrocardiogram of the Month is a series of short talks on cardiovascular diagnosis and treatment, edited by the staff of the Krannert Heart Research Institute, Marion County General Hospital and the Department of Medicine, Indiana University School of Medicine, Indianapolis.*

# *Transient Nature of the T Wave Changes*

*CHARLES FISCH, M.D.*
*Indianapolis*

IN a number of previous articles in this series, the author has stressed the nonspecificity of T wave changes. The T wave changes may occur in the absence of heart disease or may be due to a multiplicity of organic, hormonal, electrolyte changes or following administration of drugs. The purpose of this communication is to stress the fact that serious clinical coronary disease may exist without any ECG abnormalities.

Figure 1 shows a remarkable series of electrocardiograms recorded in a 52-year-old woman with classical symptoms of coronary disease. When first seen on 6-22-63, she exhibited pain of coronary insufficiency. The ECG shows striking symmetrical inversion of T waves (Pardee T waves) so characteristic of myocardial ischemia.

On 11-15-63, the patient was asymptomatic and the ECG was normal. The tracing of 3-6-64 was recorded while the patient was having pain and again exhibits changes similar to those of 6-22-63. The patient was seen again on 7-19-65, at which time she was asymptomatic and the ECG was normal. The minimal ST-T changes in leads II and III were due to digitalis.

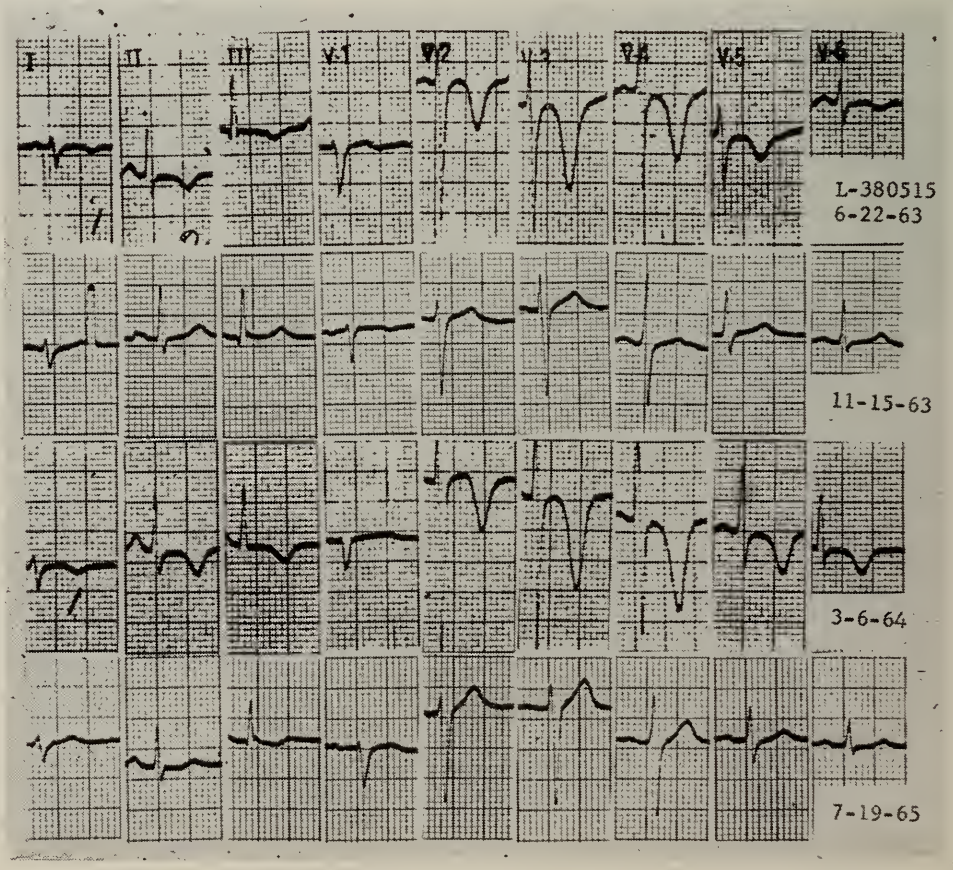



**FIGURE 1**
**SERIES of electrocardiograms showing the labile nature of the T wave changes despite presence of organic heart disease.**




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# X-RAY CONFERENCE

Presented as a regular feature of *The Journal*, X-ray Conference is a series of short talks on procedure and radiologic diagnosis, edited by Erich K. Lang, M.D.

# Hepatic Venography and Hepatic Venous Pressure Recordings in the Evaluation of Portal Hypertension

ERICH K. LANG, M.D.
*Indianapolis**

A 42-year-old white female was admitted to the emergency room of Methodist Hospital with a history of acute massive upper GI tract bleeding. The patient had first vomited bright red blood some six hours prior to admission; emesis of blood recurred at decreasing intervals. It was estimated that the patient had vomited in excess of 900 ccs. of blood by the time of her arrival at the hospital. Her history failed to reveal prior bleeding episodes.

There was no significant pain nor pertinent history of gastric or duodenal ulcer. Physical examination revealed an extremely pale, rather poorly nourished white female, prematurely gray. The abdomen was rotund and the presence of ascites was queried. A positive fluid wave, however, could not be palpated. The liver margin was readily palpated and suggested hepatomegaly. A careful history revealed alcoholic indiscretions over the past 20 years.

A barium swallow revealed massive esophageal varices. A Sengenstaken tube was anchored and bleeding was controlled by compression with the balloon. The patient was never in shock, so blood or plasma transfusions were not felt indicated.

Careful perusal of the patient's past history and comparison to old charts subsequently available revealed one previous bleeding episode some 14 years ago, at which time the patient was admitted in shock and given plasma transfusions. She was hospitalized for seven weeks, and developed a severe hepato-cellular jaundice.

For definitive assessment of her portal system, a hepatic venogram and wedge pressure recordings of the hepatic venous pressure were performed. A #7 end-hole catheter was introduced via a right antecubital vein cutdown, threaded through the superior vena cava, the right atrium, into the inferior vena cava and then, by means of a guide wire, was engaged into the hepatic veins entering the inferior vena cava at this point. The catheter was wedged and wedge pressures recorded. Subsequent to the recording of the wedge pressures, an injection of 11 ccs. of 50% Sodium-Hypaque was carried out. The injection phase was recorded on serial films (Figure 1).

The wedge pressure recordings and the hepatic venogram revealed a normal pattern of the veins and normal pressure gradients, eliminating the diagnosis of a substantial portal hypertension.

## Comment

The diagnosis and treatment of bleeding esophageal varices is, at best, a controver-

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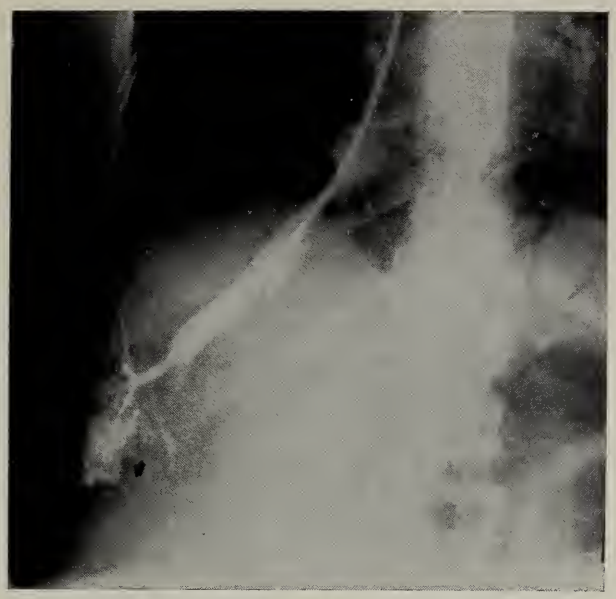


**FIGURE 1**

**NOTE the wedge position of a catheter introduced into the right antecubital vein and threaded through the superior vena cava, the right atrium and into a hepatic vein. The injection phase demonstrates normal hepatic veins.**

sial subject. Ligation of esophageal varices above or at the stomach vessels and possible construction of an Eck's fistula in cases of severe portal hypertension may be indicated. Unfortunately, the clinical diagnosis of portal hypertension has hitherto presented vexing problems. Splenoportography and pressure recordings from the splenic sinusoids have been suggested for the past 20 years. However, the percutaneous introduction of a needle into the splenic pulp has often resulted in undesirable complications, particularly rupture of the capsule of the spleen and/or subcapsular hemorrhage. Hence a new and less traumatic method has been sought.

Hepatic venography and wedge pressure recordings from the hepatic veins offer this desired modality. The method is considered atraumatic, extremely simple, and furnishes all the data necessary for a judicious decision for or against the use of splenorenal shunt, creation of an Eck's fistula, shunts of the splenoportal veins with the inferior vena cava, and/or ligation of esophageal and/or gastric varices. Though more clinical data should be compiled to substantiate the reliability of wedge pressure recordings and hepatic venography in the diagnosis of portal hypertension, this diagnostic test is highly recommended as a simple and seemingly reliable addition to the diagnostic armamentarium of this disease entity. ◄

## The Bright Future of Drug Research

Drugs of the future will be better tolerated by patients and will act with greater specificity. In the field of radiology, new agents will facilitate x-ray diagnostic procedures of the brain. Space medicine research promises to bring a beneficial fall-out of drugs for use in vestibular malfunctions, protection from harmful radiation and reduction in fatigue.

Other exotic areas of research may produce compounds that offer protection from extreme heat, and others from extreme cold. A pill that would repel insects is another possibility. The future of drug research was never brighter. The results will add to man's longevity, and will reduce the discomfort, suffering and disability of disease . . . . Austin Smith, M.D., in *Emory University Quarterly,* (21:141), summer, 1965.

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# Drug Abuse Control Amendments of 1965

"THE Drug Abuse Control Amendments of 1965 amend the Federal Food, Drug, and Cosmetic Act and place additional controls over stimulant and depressant drugs through increased recordkeeping and inspection requirements providing control over intrastate traffic in these drugs, and making possession of stimulants and depressants except under specified conditions illegal."

The above quoted sentence introduces a discussion of new legal aspects of barbiturate and amphetamine control as outlined in a reference guide published by the American Pharmaceutical Association for the information of health practitioners.

Barbiturates and amphetamines are specified in the law, but the law also uses general terms such as "depressant or stimulant" drugs. The Secretary of Health, Education and Welfare is authorized to write regulations which may include drugs other than barbiturates and amphetamines, and which may exclude drugs which do not menace public health.

The law takes effect on February 1, 1966 and it is expected that the final regulations will be promulgated prior to that time.

Each person handling stimulant and depressant drugs must prepare a complete inventory of all stocks on hand on February 1, 1966, and thereafter keep a record as follows:

*For Stimulant and Depressant Drugs Received*:

1. The kind and quantity of the drug.
2. The name, address and registration number (if any) of the person from whom received, and
3. The date of the transaction.

*For Stimulant and Depressant Drugs Dispensed*:

1. The kind and quantity of the drug dispensed.
2. The name, address and registration number (generally not applicable for pharmacists or physicians) of the person obtaining the drug, and
3. The date of the transaction.

Records must be kept for three years unless state laws specify a longer period.

The law provides that the HEW Secretary shall exempt from the provisions of the act by regulation:

1. Any drug which may be sold over-the-counter.
2. Combinations, which include one or more substances in such quantity, proportion, or concentration sufficient to prevent the stimulant or depressant drug from being ingested or absorbed in large

enough quantities to cause the stimulant, depressant or hallucinogenic effect.

Physicians and other licensed practitioners who regularly engage in dispensing stimulant or depressant drugs to their patients and who make a charge for the drugs "either separately or together with charges for other professional services" must also keep records of receipt and disposition and make them available for inspection.

Stimulant or depressant drugs may be dispensed on telephoned or oral instructions according to the usual practice. No prescription order can be renewed more than five times and no prescription order can be dispensed or renewed more than six months from date of issue.

Possession except as authorized by law, failure to keep accurate records of receipt and disposition, refusal of access to required records and refusal to permit authorized inspections are violations of the law in regard to the activities of pharmacists and physicians, and dispensing or renewing any prescription more than six months old or for more than five times, even if ostensibly authorized by a physician, is a violation for the pharmacist.

Regulations to be published in the future will specify the drugs to which the law applies.

***Guest Editorial***

# *The 50-Year Club**

FIFTY YEARS is a relatively short period of time in the life of the medical profession. It is a long time, however, in the life of the individual physician.

In retrospect, we see the past dimly through the mist of time—much like in a dream—sometimes clearly and other times, cloudy. The past is gone; the past is dead; but our accomplishments will continue to live on. The past is now history; the writing of the record must be left to the historian.

We are most fortunate to have lived in this exciting age. I am confident history will show that more progress has been made in the last 50 years than has ever been made in any similar period of time.

For half a century we have had a ringside seat from which to watch the parade of medical progress. Diseases, once thought incurable, are now curable, preventable or controllable. We have seen the marvels of drug therapy, the antibiotics, sulfa drugs, tranquilizers and hundreds of other useful drugs now in the hands of the modern physician.

No longer do we rely on roots and herbs, mustard plasters and the many other innovations of yesteryear.

We have taken great strides forward in determining the cause of illness. Diagnosis is no longer an educated guess—it is to a large degree a sound conclusion, based on scientific information, provided by the x-ray and clinical laboratory.

The advances in the field of surgery and surgical technic border on the spectacular. Portions of the anatomy once considered surgically untouchable now are the sites of commonplace operations.

Brilliant results have been obtained from surgery on the brain, the lungs, the heart and the vascular system. Tissue transplants and the transplanting of kidneys and other organs are producing encouraging results.

The end is not yet in sight; progress marches on and we can expect many benefits yet to come from this atomic age.

We are so occupied with events of today, so interested in the future, that we have little time to reflect on the past. These are changing times, mostly for the good. But there is reason to believe that not all is good, and that danger signals, lurking in the background, may have been ignored.

We appreciate the good fight the officers of our association are making against those who would destroy the private practice of medicine. We are grateful for the hard fight you are making against those who would trample upon organized medicine and

* Response made by Charles W. Myers, M.D., Indianapolis, at the induction of the 1965 class of the 50-Year Club October 14, 1965, at the Murat Temple.

crush it under the heel of political favoritism.

We are deeply grateful to the officers of our association for the recognition they have given us for our years of service. We appreciate it very much, and every member of this year's class joins me in saying *thank you.*

## Editorial Notes...

**Accidents disable 10 million persons annually and kill more than 100,000 besides accounting for 22 million hospital bed days each year.** "Accidents—A Preventable Epidemic" will be the theme of the AMA Environmental Health Congress to be held April 4 and 5, 1966, in the Drake Hotel in Chicago. For full information write to the Department of Environmental Health at 535 N. Dearborn Street, Chicago.

**Computers are in the blood bank business.** Large and complicated inventory and resupply problems have been solved by computers for some time, but now it is evident that blood bank inventories are susceptible to computer control. The Alameda-Contra Costa Blood Bank of Oakland serves 28 hospitals with a total bed capacity of 4,600. Daily reports of blood usage go from the hospitals to the Lockheed computer. The system has enabled the bank to reduce its inventory by from 15 to 20%. The loss of outdated blood has dropped from 13% to six percent, and the average age of transfused blood has been reduced from 10.7 to 9.5 days.

**1965 will be the first year since 1959 in which the number of new drugs introduced has increased over the previous year.** Sixty-three new single chemical entity products were introduced in 1959. Each subsequent year showed a decrease in new drugs, with a low of 17 in 1964. There had been 17 new introductions by September of this year and it is estimated that the total for 1965 will be 25. ◄

## *About Our Cover*



Just for a few hours on Christmas Eve and Christmas Day, the harsh mechanism of the world runs down and we permit ourselves to live according to untrammelled common sense, the unconquerable efficiency of good will. We grant ourselves the complete and selfish pleasure of loving others better than ourselves. How odd it seems, how unnaturally happy we are!—From "Old Thoughts for Christmas," by Christopher Morley, 1919.

# President's Page

The position of the medical profession under the provisions of Public Law 89-97 (Medicare) will be most difficult and perhaps even untenable. The many provisions of the law, augmented by regulations now evolving from the Department of Health, Education and Welfare, will be staggering to many physicians; and the worst is yet to come.



It is important to each of us that we take sufficient time to carefully read at least a summary of provisions of the law and regulations (these will be provided to you as soon as possible).

This is not a bad dream that will go away—rather it is a problem that will haunt us from this day forth. Our actions in the next six months will determine our future and the future of medicine.

Many of you have expressed the opinion that the hospital-based specialists are the only physicians seriously involved. Nothing could be further from the truth. We are all involved *now* and will be even more deeply involved in the future. Under Title XIX, nearly every physician will be involved in many ways within a few years.

As soon as regulations are promulgated by HEW, each county medical society, each hospital staff, and each physician must carefully study the regulations for physician certification, payment, utilization committee, etc.

We must carefully investigate each area and attempt to provide the maximum protection for our patients with a minimum disruption in care. We must carefully study the mechanism for payment of physicians' services, and I believe we must firmly adhere to the policy established by the House of Delegates of the ISMA; direct billing of the patient and the usual and customary fee concept. We must remember, too, that this requires certain *local* medical societies to review procedures to insure that these are usual and customary fees for a specific type of service in a specific area. Anything less will react to the detriment of the profession.

You must decide whether you will participate in and make the utilization committee effective or whether you will abdicate your responsibility under the law to a government agency. You must emphasize—and I think you must support—the principle that the hospital-based specialist is and must be an independent practitioner of medicine. You must determine who can best negotiate for your fees and can best understand your position when disputes develop—I think it must be your state medical society.

We must calmly assess our position, our weaknesses and our strength; and then develop and maintain a positive program.

*Above all,* we must remain united.

As we approach the end of another year—chaotic and frustrating as it has been—we can take some reassurance from the fact that we are still able to freely express our views. In the coming year, let us not default on any opportunity we may have to preserve our freedom.

My sincere wishes for a Happy Holiday Season for you and your families.

R. O. Neumann M. D.

# *The Woman's Auxiliary*

## REPORTS TO ISMA

Our Christmas gift to our doctor husbands is a reaffirmation of our desire to establish rapport between physician's families; insure the advancement of Medicine and the health of the public; promote general welfare in our individual communities and secure the blessings of liberty to ourselves and our posterity.



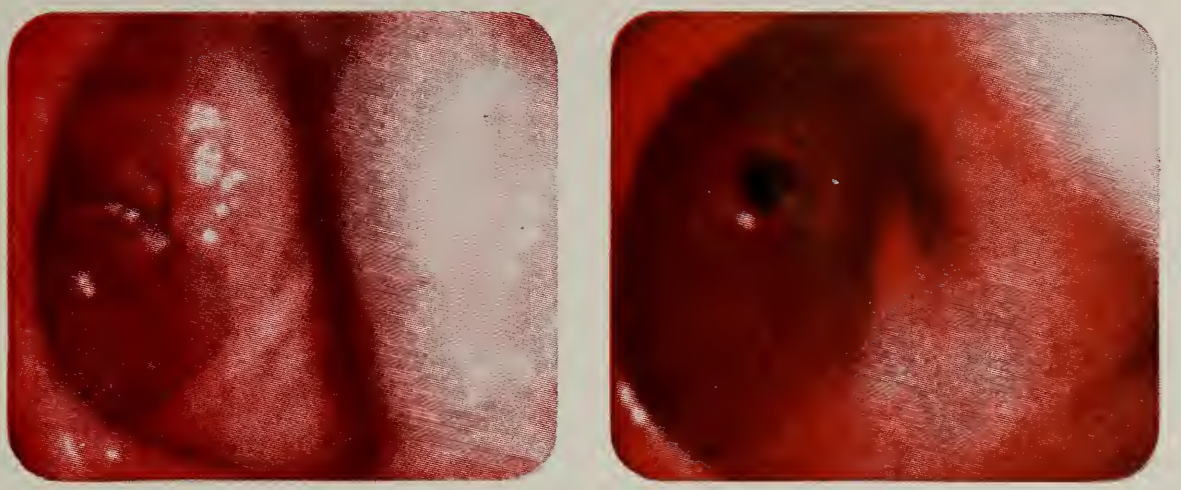
The medical profession's goal must be to prevent Medicare from being extended to cover larger segments of the population. We shall join in the strategy to inform ourselves and the public about the dangers of this extension. We shall educate ourselves to identify issues clearly and sustain our concern and activity in political education and action. This, with your support and encouragement, we promise.

We shall attempt to budget our time wisely, with regard first to the needs of our family, realizing we must often fill the role of both parents. Patience and understanding are virtues to be nourished in a wife when the demands of an active practice keep the physician away from his home. Hours of family togetherness must be planned and carefully guarded by husband and wife as a team.

We are convinced doctors are very special people; being married to them makes us—special, too?

Ruth V. Dunstone





## Intragastric photography studies[1]

**A/** E. B., male, age 48. Normal antral contraction. Pyloric opening is not seen. It is difficult to differentiate a deep prepyloric contraction from a "pyloric fleurette" or true pylorus.

**B/** Same subject after 6 mg. of propantheline bromide intravenously; antral contractions ceased. The pyloric orifice remained open and was easily identified. Better visualization of the antrum was also obtained.

# Now you can see Pro-Banthine® at work
(propantheline bromide)

Pro-Banthine is so effective in anticholinergic action that it may be employed in visualizing the entire pyloric region.

In addition to the intragastric photographs, cinegastroscopic studies[2] have demonstrated graphically not only its effectiveness but the superiority of Pro-Banthine over belladonna alkaloids.

Pro-Banthine produced complete cessation of gastric, antral and pyloric motor activity with a dose of 6 mg. intravenously. This is approximately one-third the usual oral dose of 15 mg.

Atropine at full normal dosages did not produce such cessation. It required double the usual oral dose of atropine, 0.8 mg. intravenously, to duplicate the aperistaltic action of Pro-Banthine. This dose of atropine produced pronounced discomfort and tachycardia with ventricular rates as high as 150 per minute.

It is this pharmacologic superiority of Pro-Banthine which has made it the most widely prescribed anticholinergic in such conditions as peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

**Dosage**—The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15 mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

**Side Effects and Contraindications**—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

1. Barowsky, H.; Greene, L., and Bennett, R.: Investigators' Clinical Report. Photographs courtesy of Drs. H. Barowsky, L. Greene and R. Bennett.

2. Barowsky, H.; Greene, L., and Paulo, D.: Paper read at Meeting of American Society for Gastrointestinal Endoscopy, Montreal, Canada, May 25-27, 1965.

SEARLE

*Research in the Service of Medicine*

# Handle My Tissues with Loving Kindness*

"JULES BERNE, M.D."
Indianapolis

THE YEAR is 1994—the occasion—Dr. Caleb Stansby's first serious illness. The return to his homeland had been a disagreeable and rueful occasion. He had left Bangsburg as a young practicing physician 60 years before to do missionary work in Africa. The only M.D. among a group of ignorant, uncivilized aborigines, he became their physician, surgeon, minister and leader. He learned their dialects and listened with empathy to their woes. He had strived diligently to understand the nature of their afflictions. His was indeed a lifetime career which excluded even a normal interest in medical progress. Thus he had little access to current accomplishments in medicine or its many basic and allied sciences.

Home scarcely three weeks, he had already begun to peruse American scientific journals, and much to his disappointment, they had become almost unintelligible. He would perforce learn new vocabularies, nomenclatures, designations and technical terms. He noted that articles were brief and in what he called telegraphic style. But in this short time, he could already see and understand that the modern world was scientific to a point where the humanities were almost forgotten; ethics, esthetics and metaphysics were of academic interest only.

Philosophy and logic had been deemed unnecessary because of machine thinking. It was every man for himself, competing for more and newer scientific developments. Teamwork was de-emphasized and the desire to help each other did not exist. "With our machines, we need no cooperation," a famous scientist had written. Dr. Stansby was depressed in mind as well as physically ill. He could not and would not truckle to those who would completely exterminate a kindly thought or a humane deed.

His expression showed his thoughts clearly and unmistakably. Time and compassion had conspired to etch the furrows and lines upon his weather-toughened face, producing a portrait of mercy and forbearance. Tall and sinewy, he had been very strong in his youth and was described by his wife Margaret as a man with the strength and fearless courage of a dauntless warrior but with the tender touch, love, faith and credulity of a trusting child.

### Neologistic Nurturing

Now on January 5, 1994, ill, forlorn and discouraged, old Dr. Stansby entered a large modern clinic on a conveyor-belt chair. While enroute, an unseen voice began interrogating him.

"Sir," the voice asked, "how old are you?"

"Born in 1901—93 years old," came the reply.

"Occupation?"

"I am an M.D. and missionary and have been since 1924—that's not all, I'd still be practicing if that damned old-age-inhibitor medicine had been available years ago."

"What makes you think you are sick?" the voice continued.

"I can't walk well and I can't remember things. I eat well, sleep well and have normal elimination—that is, considering these crazy 'pill meals' that I'm on. By the way who am I talking to?"

"Sir," the voice replied, "you are speaking into a medical computer. All of your symptoms and signs will be electrically fed into a machine. The diagnosis will be automatic—no human hand need touch you, no eye see nor ear hear you."

The chair in which Stansby sat was propelled by electricity and required no effort on his part. Even the station could be selected on the chair by pushing a button. Moreover, it stopped automatically, not by brakes and their frictional resistance but by repellent electrical force, accurately and precisely at the right point.

The chair had now arrived in a small

* Part I of a two-part article.

room containing a huge electrical panel with large letters and figures.

"This is a hell of a note," Dr. Stansby mused. "Imagine consulting a physician and all you see or hear are machines. It's like calling on your girlfriend and being told that you don't need to hold her in your arms, love, marry and enjoy each other in establishing a family, because it can all be done by artificial insemination. In fact, I have read that one may go to the Artificial Insemination Bureau; here the female selects from catalogued 'semen contributors' the kind of child she desires. She also chooses the sex, color of hair and eyes and the general characteristics she wishes. The length of gestation has been shortened to three months and the child is born healthy and free from all congenital defects. The whole practice of medicine has come to be a mass of electronics. The human brain is obsolete, isn't it?"

The voice interrupted his thoughts, "Please void in the receptacle that has appeared from machine number A-1. As soon as you have finished, your chair will move to A-2. Place your right arm in the cuff which is now extended for you. You should be told, sir, that a sample of blood will be automatically withdrawn. The flow meter locates your vein by electromagnetic changes and blood samples are withdrawn automatically."

"That's a damn sight easier than drawing it into a syringe by hand," thought Stansby.

### Elocutionary Electronics

He was now in a room like a labyrinthian beehive of small partitioned spaces, each with bizarre and grotesque instruments that at times appeared and disappeared as though commanded by an unseen prestidigitator.

The voice again, "Please, sir, move your chair to station B-1. Up to this point the number of blood cells and the chemical and cellular constituents of your blood have been analyzed by our electrical counters, photometers and analyzers."

The voice continued, "Now you will receive an injection of functional pellets. These are so small they go into every vessel and capillary in every organ of your body. They are tiny radiographic and audiographic machines. You remain here for one hour. Then the machine collects all the pellets, which have been emitting radiation signals from every part of your body. Each group has a different sound, identifying each and every organ. You should also understand that these microspheres are tiny TV broadcasting units, and our fluorocinograph will make a TV videotape of every organ."

"I don't believe any of this stuff," yelled old Caleb.

"Rest period now, while I explain B-2 machine," said the voice. "We now know all about your blood and every organ in your body. B-2 studies not microbiology, but molecular biology. This is accomplished with infinitesimal atoms the size of our smallest virus, like the cancer virus. It tells us the inner workings of the cell and the arrangement of molecules, atoms and genes. It works like a TV satellite on Mars, Jupiter or Venus, or like those used before the moon was reached. With this machine we know what you have, what you have had, what you are going to have and how long you will live. In other words, whether you are worth reconstructing and repairing."

This was too much for Caleb. "Let's quit all this nonsense," he roared, "but who in the hell do I talk to? Who are you?"

Once the automatic chair arrived at station B-1, the moves were made without the patient's control. It reminded Caleb of the old canning factory in Bangsburg where the tin cans came along on a moving belt. Ladies filled the open tins with tomatoes, which were then capped, cooked and labeled by what was then called the new "monster" machine.

### Canned, Capped or Cooked?

Soon the conveyor was moving and the old doctor found himself encased, chair and all, in a large soundproof cylinder.

"Do not talk or move while our molecular video tape is working," said the voice.

"Now, listen, whoever is here, don't you take x-rays or use fluoroscopy anymore?" asked Caleb.

No answer, but a pause of reflection told the old doctor that x-ray and fluoroscopy were no longer necessary when they knew

what each cell and each molecule in each cell was doing.

Within one hour the entire examination was over, and the voice concluded, "Sir, our computers and mechanical brain have now catalogued your entire body and you will see your physician tomorrow at 8 a.m."

"What a strange medical world this is as compared with my younger days," Caleb thought. "I am happy my dear Margaret is no longer here to witness it. She at least tasted of that sweet and precious nectar given only to those who spend their lives helping others, even though their enchanting and gratifying enterprises ultimately consume them." Looking around, he thought, "These gadgets can't know what's the matter with you, and if they do, so what? I guess I haven't kept up too well."

But secretly Caleb was eagerly anticipating a meeting with someone called "your physician." He wondered what this man looked like; how he gained his knowledge; how complex his course of study was; what subjects he had taken; and now, what he could do about disease in general.

The patient spent a restless night anticipating the excitement of tomorrow. At long last 8 a.m. arrived and he was conveyed into the examiner's office.

### Heterogeneous Hydrocephalic

"You are Dr. Stansby, I believe," began the doctor. Caleb couldn't believe his eyes. A little man with a large head—one that he would have thought to be hydrocephalic. Little legs, minute eyes and ears and practically no fat. "Doesn't this man come from another planet?" he thought.

"I am Doctor Mathews."

"Well," continued Mathews, "our computers and analyzers have come up with your diagnosis and prescribed the proper treatment."

"Maybe his computers know my thoughts too, in their weird, surreptitious way," thought Caleb. "If so, it's all nuts."

Caleb couldn't contain himself any longer. "May I ask you a few questions, doctor?"

"Certainly," replied Dr. Mathews.

"How many patients do you see per day?"

"Roughly, 500," came the reply.

"Do you see that many with neuropsychiatric problems?" asked Caleb.

Continued


# DEPROL®

**meprobamate 400 mg. +**
**benactyzine hydrochloride 1 mg.**

**Indications:** 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

**Contraindications:** Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

**Precautions:** *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

*Benactyzine hydrochloride*—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

*Meprobamate*—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Dosage:** Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

**Supplied:** Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.
*Before prescribing, consult package circular.*

WALLACE LABORATORIES / *Cranbury, N. J.*

FOR THE




COMPLEX

# TRY DEPROL®

meprobamate 400 mg. +
benactyzine hydrochloride 1 mg.

a logical first choice

# FOR DEPRESSION

even when complicated by anxiety, tension, insomnia, agitation or rumination.

- Acts rapidly.
- Side effects at recommended dosage infrequent, usually easily controlled.

"Yes," was the answer, "because our molecular and biological computers tell us what is wrong with the brain cell. Now I must tell you what's wrong with you and what you need, to become well again.

"First of all, you have no very serious disease by modern standards. As you perhaps know, cancer is now preventable by our anti-cancer virus vaccine. You haven't had this vaccine, but I shall give it to you. All infectious diseases are also preventable by vaccine. You shall have this, too. Physical worn-out parts are now replaceable, and had you taken our 'anti-atherosclerosis serum' you would not have this disease now. Your brain is not too good, so I shall give you a brain food to nourish your nerve cells. It is a new vitamin, not unlike vitamin B which was formerly used for beriberi in your era. You need larger blood vessels and a new left ventricle in your heart, and then you'll be young again. I shall meet you in the hospital tomorrow at 11 a.m."

Amazed, bewildered, speechless and thoroughly unconvinced, Caleb turned his wheelchair onto the conveyor and was whisked away to his hotel room.

He was tired and helpless. What should he do? He must talk to someone. But who? In his desperation, and feeling foolish for bothering the man he had known for only a few short hours, he decided to call the weird Dr. Mathews and ask him to dinner. "But there isn't any dinner as we used to know it in the old days," he thought. "Now it's mostly concentrated hardtack pellets and pills."

He decided to tune in on Dr. Mathews by way of television and asked, "Would you permit me to talk with you over the television?"

"I'll do better than that," replied Dr. Mathews. "I'll put you on our moving sidewalk and you will be delivered to my home. Okay?"

"Wonderful," exclaimed Caleb.

### Cylindrical Cellules

The air was invigorating, and Caleb was so full of questions that he could hardly wait for his conference. Where had he been for the past 60 years? He hadn't cracked a book, and he didn't believe all this stuff he was now seeing on television. He felt like a bibulous Rip Van Winkle after a 60 (instead of a 20) year sleep. Could the modern world have changed so much since his departure?

Caleb noticed the homes. They were extremely tall cylindrical structures. They reminded him of a series of giant round silos such as he had seen on farms. Only these "silos" were stacked one atop the other, and were staggered in their ground positions so that there was a minimum loss of space. There were no windows and each unit seemed to turn clockwise or counterclockwise independently of those above or below it. The entrance into a section was only visible at times; there was only one entrance, therefore it served also as an exit. This was a weird sight—flat dextro and levo rotary cylinders. "Are these the answer to crowded living?" he wondered.

When he arrived at Dr. Mathews' home, the conveyor belt lowered and Dr. Stansby was taken into the doctor's house. Or was it a home? It looked like one room. It was one room. He wondered where they slept and ate, and what their recreation was. He would soon learn.

"Welcome to our little home," Dr. Mathews began. "You look surprised and disturbed."

"Well, yes, I am," Caleb stuttered. "Does your whole family live here? How old are you? Do you live with your wife? Do you have children?"

Dr. Mathews' reaction was ambivalent as he reappraised his wrinkled old patient. "Hold on a second," Mathews replied, "one question at a time. Your ability to interrogate is almost as good as that of most of our modern machines."

"Well, Dr. Stansby," Mathews began, in an amused voice, "you are certainly out of touch with the modern world. You still live in your old house. You think you're old at 93 and that the population of your community in Bangsburg is still 3,000. Well it isn't. Your town population is now 300,000 and growing so rapidly that your home with all its rooms takes up too much space. What were farms are now cities. Therefore, your 'pill diet.' Children of this generation will

live to be 250 to 300 years old. The only cell we haven't completely conquered and replaced is the nerve cell, but this will come—I tell you, it will come."

He continued, "We have no exercise, and we don't need it. All we need is brain power. Look at my body as compared with yours. It's small, isn't it? I don't need it except to house my brain. The old synapses that cluttered our brain are no longer needed because computers do all ordinary thinking for us. My brain is free to invent new ideas. I am supremely happy because each day I become a better physician. Therefore each day I am more free to talk and act because I know more about my subject. The same is true of our engineers, physicists and every other profession or occupation. We need very little of the so-called unskilled labor of your generation. Population is growing too fast though. Very few babies are lost, and men and women retain their youth."

### Extirpated Empressement

"May I assume," broke in Caleb, "that you have a wife, and you do have sexual relations and all that?"

"By Jupiter and Mars," thought Mathews, "this old boy is not much higher than the earliest Homo sapiens—the Neanderthal man or Cro-Magnon."

"Of course we do occasionally," Mathews began, showing his surprise at the audacity yet candid honesty and simplicity of his guest. "But this gratification and carnal pleasure is not important anymore. We have more trenchant purposes in life now. We can control pregnancies, so this is not a problem. We can even regulate the sex of our babies. However, as you can readily understand, this must remain the prerogative of trustworthy physicians only, because there must be a distribution of sex."

"I thought," continued Caleb, "that you could produce life in vitro now."

"Yes we can, old fellow," came his reply, but we are not yet sure of our products by this method. I am looking forward to the time when this form of reproduction will be reliable, so that fornication will not be necessary for procreation. We have artificial placentae and uteri and we can grow babies artificially. This is very interesting, and I know that some day it will be perfected but as yet, it is unreliable."

Caleb's eyes told of his horror. Could this be true? Was there no love, no thrill, no mutual gratification or satisfaction in producing a family? "Ah, the fun they miss. They are devoid of all emotional attributes," he thought. But before he had a chance to completely assess his host, Mathews proudly continued, interrupting Caleb's thoughts.

"Let me show you our home. You think it's one room, but it isn't. Stand over here next to me in this center area and watch!"

Dr. Mathews pressed a button on the wall, and the entire apartment revolved; flexible partitions dropped seemingly from the ceiling. "I am going to show you our bedroom first. May we come in, Satt?"

Mrs. Mathews' real name was Satellite but she had never used it. All who knew her called her by her nickname. She was on a lounge reading. When Dr. Mathews called her, she pulled a switch and chairs were lowered from the walls. The beds remained hidden in their niches.

"Yes, come in," she said. There were no inside doors as Caleb knew them—only opaque screens formed by millions of longitudinal threads, operated by a photoelectric cell. The long plastic threads separated easily as one entered, then closed.

"No, no, we aren't going to stay," Dr. Mathews said. "This is Mrs. Mathews, Dr. Stansby. She is reading a book by way of electronic-audio-transcription. She can read an entire book in an hour this way, without using her eyes and thereby preserve them."

Mrs. Mathews looked up and gave Caleb an expressionless nod. Her complexion was sallow, her skin smooth and unwrinkled, her demeanor phlegmatic. Her dyed blond hair was sparse. Her narrow shoulders and bosomless chest made her appear unfeminine but not masculine. By Caleb's standards, she was an uncomely young woman.

It was apparent to Caleb through conversations with Dr. Mathews that each room radiated from a central pivot platform which really constituted a rotating circular hallway. It reminded Caleb of a thick pie with the center reamed out. The pieces of pie resembled the shape of the rooms. Each room was a four sided figure with the outer and inner lines parallel but not equal and

the two sides equal but not parallel. He remembered something about an isosceles trapezoid in his high school days, but he wasn't sure.

### Metaphysical Marvels

Dr. Mathews was talking to him, bringing him up to date on every detail. "The heating and air conditioning with filtered air are scientifically compounded. Percentages of oxygen, nitrogen and carbon dioxide are individually proportioned under barometric pressure desired and needed by the families living in the extremely high top floors where hypobarism exists, and the very low underground quarters where hyperbarism is present.

"Light is artificial and abundant and considered to be much less dangerous to the eyes, skin and bone marrow than the fallout from sun rays. In fact, sunlight is captured, stored in large chemical vats and used for heat; light is retained in photosensitive fluids, and even radioactive material is now absorbed by blended elements." He pushed another button, and the boys' room came into view. "This is Rocket and Booster," Mathews announced. "You see they are not studying books as you know them, but machines, electronics, atoms and molecules. Chemistry and physics are now one, because it is the atoms making molecules that determine physical or chemical properties. You know planes now go 4,000 miles per hour, space will soon be zero, time is no factor, and mass is a composite of atoms and molecules."

Dr. Mathews pressed a switch and proudly announced, "Our two girls, Star and Orbit, are out for the evening. This is their room. Now I shall pull this lever and show you my study. Look, there are no books—just small capsules containing the entire book on film. Authors don't type anymore—they speak into a teletype and their book is automatically transcribed, proofread and corrected by machine." Caleb was amazed, and he marveled in awe and wonderment at these mechanical accomplishments. But his aged legs ached, his ischemic buttocks were tired and his sight was somewhat blurred from fatigue, despite his strong-lensed spectacles. He would have welcomed a break in the tour.

"Now, let's go back to the living room by panel control and you may ask questions," Dr. Mathews announced.

"Don't you use electrocardiography, angiography or electroencephalography any more?" asked Caleb.

"No," replied Mathews, "no longer necessary. If you know what the cells are doing and how they are behaving, the machines come up with the correct answers. But now, Dr. Stansby, the hour is late, and although I need only three hours sleep, I have a heavy day tomorrow. You are entering the hospital tomorrow, remember?" Caleb did not answer. He could not conceive of the rapidity of movement, the new ideas with seemingly a complete absence of time for happy thoughts, to say nothing of recreation, in the modern America.

Should he remain at home or go back to what was left of the jungles? For him one extreme was as good or bad as another. One way was the full life, with time for contemplation, fun, gaiety, laughter, joy and a zest for living; the other was a serious, ultra-scientific mode of existence that was overwhelming. One could easily observe the constant restless seething, the endless and unbridled desire to invent and to discover the new, the unknown and as yet unseen minutiae as well as distant worlds. Finally, as if aroused from a stupor, he managed to blurt out, "Thank you, Dr. Mathews."

### Hospital Habitant

A heavy snow was falling on the cold January morning that Caleb entered the hospital. The conveyor belt was heated and dry, and there was no problem. The building itself was very large and cylindrical, and each floor was a series of concentric circles which Caleb could not understand at first.

A folder given him on admission gave a full description of the buildings and their purposes. Caleb studied it as he waited in his room for preoperative instructions.

The series of ten concentric circles, each with outer and inner rooms, were all connected by radial hallways like spokes of a wheel. The hub was a huge central station with complete electronic devices, including television and temperature, pulse and blood pressure records. Patients could be seen, examined and reassured by electric controls.

In the outermost circle were the intensive diagnostic units for all kinds of covert medical problems. The innermost circles were the intensive care units. There were separate areas for various diseases and different types of therapy. Distinct sections for urology, psychiatry, pulmonary disease, gastrointestinal disease, gynecology, obstetrics and other divisions were described in the booklet.

Each ward had its sector for different kinds of surgery, but invariably the innermost circle, close to the hub, was devoted to the sickest people, whether medical or surgical. The "hub" was turned by electronic control but, unlike the apartment homes, the various floors were not movable.

Although there were 30 stories, the pattern was the same for every floor. An interesting feature was the arrangement made for convalescent patients, with two divisions: self-care and care with the aid of electronic devices. There were no windows and the air was a scientific mixture of gases under suitable barometric pressure, at various temperatures and humidities depending upon the type of disease and its treatment.

Caleb's reaction to this plan was good. He had, indeed, thought of some similar arrangement for hospitals during his active career. But his opinions and advice were disregarded and three people had been necessary to care for every patient. Now there was only one trained attendant for every 500 patients. Of course, the electronic devices were not available during his time in active practice, either. The horrible bedpan had not yet been replaced by an automatic bed "disposal" and patients were not turned, bathed and fed by automation as they were here.

Since Caleb's workup was complete, he was scheduled for surgery the following morning. He made one remark to the attending surgeon, Dr. Jeffrey K. Boswell, who came in to see him before his medication became effective. "Remember, young fellow," Caleb said, "even though you surgeons are apparently human precisional machines, if you handle my tissues with loving kindness, they will respond in a similar manner."

Dr. Boswell made no comment but as he turned around to leave the room, he thought: "This old M.D. knows absolutely nothing about our self-regulating surgical machines based on computers, which determine and control every move in modern surgery."

Days later, after his operation, Caleb had recovered sufficiently to read of the multitude of atomic devices that controlled barometric pressure, heart beat, respiration and temperature by remote control outside of the surgery. His own circulation, he learned, had been interrupted with three atmospheres of oxygen pressure in a hyperbaric chamber while the main arteries and part of his heart had been replaced with a new synthetically produced material. Delicate wires were entwined within its elastic mesh. These new parts responded to electric batteries the size of a grain of sand which gave the impulses synchronized with normal heartbeat and pulsatile flow. Moreover, the batteries were automatically recharged and lasted a lifetime.

Caleb talked with everyone he met about the wonders of medicine, electronics, atomic energy, physical chemistry, astronomical medicine, and the relation and interdependence of all medical and allied scientific disciplines. "Medicine and allied sciences are moving so fast that a year today is like a decade in my generation," he confided to a fellow patient.

"I have been a laggard in following medical progress, and I find it all too incredible and difficult to perceive. Maybe I can catch up, contribute my tiny bit to that part of medicine which now seems unattainable," he thought. Had Caleb been inoculated with a "research antigen?"

**(To be concluded next month).**



# Maternal Mortality Study Committee Report of 1963 Maternal Deaths*

INDIANA had 106,956 births in 1963. Maternal deaths for 1963 totaled 26 for an official maternal mortality rate of 2.4 deaths per 10,000 live births.**

The committee reviewed a total of 41 deaths which occurred in 1963 and in which the women were either pregnant at the time of their death or had been pregnant within the past year. Of the 41 deaths studied, 35 were, in the opinion of the committee, determined to be related to pregnancy and were, therefore, regarded as maternal deaths.

As to the actual causes of death in these 35 maternal deaths, 10 (29%) were due to infection, five (14%) were due to hemorrhage, seven (19%) were due to toxemia and three (9%) were due to amniotic fluid embolism. Anesthesia, air embolism, chronic pyelonephritis, pneumonia, sickle cell disease, adrenocorticosteroid deficiency, suicide, choriocarcinoma and bowel obstruction were the cause of one death each. A definite cause could not be determined in one case. Table I shows the number and causes of death.

The cause of the hemorrhage was ruptured ectopic pregnancy in one case, ruptured uterus in two cases, spontaneous abortion in one case and hemorrhage-other in one case.

Infection accounted for ten deaths. Septicemia resulting from self-induced or criminal abortion caused five deaths. The other five occurred in patients delivered by Cesarean section, one for ruptured uterus, two following prolonged ruptured membranes and two without demonstrated etiology.

Table II shows the number of deaths by age group and Table III by parity. Twenty-seven of the women were white; eight were of other races.

As to prenatal care, 10 patients had none, two sought care in the third trimester, eight in the second trimester, nine in the first trimester and it was unknown in six cases.

Autopsies were performed in 29 of the cases.

Table IV shows the results of pregnancies with reference to the infant.

### Summary

There were only six maternal deaths in which autopsy was not performed, which is a very creditable situation. Two of these were patients in whom rupture of the uterus occurred after previous Cesarean section and were unequivocal; one was from infection following Cesarean section; one from crises in sickle cell disease; one from anoxia following aspiration during anesthesia with cardiac arrest and one was probably embolic but undetermined.

One other ruptured uterus, with death from hemorrhage, and all three instances of death due to amniotic fluid emboli were confirmed at autopsy. Eclampsia caused the death of two of the five primigravidas who died; ruptured ectopic pregnancy caused one and infection caused the other two—one after Cesarean section. Seven of the deaths followed Cesarean section, five of which were due to infection.

Most of the deaths were preventable in the opinion of the committee.

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Elwood J. Meredith, M.D.
Mahlon F. Miller, M.D.

* The seventh report of the Maternal Mortality Study Committee of the Indiana State Medical Association.

** Indiana State Board of Health reports.

NUMBER AND CAUSES OF DEATH

| Cause | Number of Cases | | | Percent |
|---|---|---|---|---|
| | Under 30 | 30 & over | Total | |
| Infection | 5 | 5 | 10 | 29 |
| Hemorrhage | 1 | 4 | 5 | 14 |
| Toxemia | 5 | 2 | 7 | 19 |
| Amniotic fluid embolism | 2 | 1 | 3 | 9 |
| Other | 4 | 6 | 10 | 29 |
| | | | 35 | 100% |

TABLE 1

DEATHS BY AGE

| Age of Mother | No. of Deaths |
|---|---|
| Under 20 | 2 |
| 20 - 24 | 9 |
| 25 - 29 | 6 |
| 30 - 34 | 11 |
| 35 - 39 | 7 |
| 40 or over | 0 |

TABLE II

NUMBER OF DEATHS BY PARITY

| No. of Pregnancies | No. of Deaths |
|---|---|
| 3 and under | 16 |
| 4 and over | 15 |
| Unknown | 4 |

TABLE III

FETAL OUTCOME

| Lived more than 24 hours - 15 (1 set of twins) | | Stillborn or lived less than 24 hours - 8 |
|---|---|---|
| Under 5½ lbs. | 1 | 3 |
| Over 5½ lbs. | 12 (1 set) | 3 |
| Weight not recorded | 2 | 2 |

Not delivered - - - - 13
1st trimester - 8
2nd trimester - 3
3rd trimester - 2

TABLE IV

# Gleaned from the British Medical Journal

JACK W. HICKMAN, M.D.
*Indianapolis*

### News of Retarded Infant Best Given Early

One of the most difficult problems that confronts physicians is judging the proper time and method of telling a new mother that her baby is mentally retarded. Drillien and Wilkinson[1] interviewed 71 mothers who had given birth to mongols in order to assess their opinions regarding the timing and nature of this information as it was given to them. The most appreciative mothers were those who had been told or warned very soon after the birth of the child that it would be severely retarded. The mothers also desired a full explanation either at that time or within three months after delivery, and were most appreciative if they were encouraged to return to the physician with any further questions or problems. The follow-up visits and support given by the physician were judged to be very helpful. The most resentful mothers were those who suspected that their infants were not normal but had been told not to worry when they had sought further help and advice.

### One More Advantage for Ethyl Alcohol

Sales, cost and net income of iron and vitamin preparations have all increased when they have been marketed in an ethanol base. Actually, the study by Charlton, et al.[2] demonstrates that there may be other advantages to such packaging methods. The authors measured ferrous and ferric iron absorption with and without alcohol intake in 31 normal subjects. Their results show a markedly increased uptake of the ferric iron with alcohol ingestion, but there was no enhancement of ferrous uptake. Further long-term studies coupled with an assessment of total body iron stores, reticulocyte counts and further modifications of this study could also prove interesting.

### Birth Injury Involves Obstetrician

At least one obstetrician has personal knowledge of the great contractible strength possessed by the uterine musculature. The case report by Beck[3] describes a fractured third metacarpal suffered by an obstetrician during a Caesarean section when his finger was trapped in the incised uterus by a strong uterine contraction. Mother, child and obstetrician all made uneventful recoveries.

### Reliable Blood Sugar Reports By Paper Strip

Another large series of successful use of Dextrostix measurement of blood glucose determination is reported by Marks and Dawson.[4] This report is of 356 individual determinations by the Dextrostix method as compared with the standard true glucose method. The authors found a high degree of correlation between the paper strip method and the laboratory method for determinations in the 40-200 mgm.% range. The authors confirm other findings that observer error can be significant and that the one minute end-point must be adhered to closely in order to obtain the most accurate reading from the strip.

### Coronary Disease and Arcus Senilis

McAndrew and Ogston have investigated 100 post-myocardial infarction patients and 100 control patients to see if there is a positive correlation between coronary occlusion and the presence of early or marked arcus senilis.[5] Serum cholesterol, blood pressure and body configuration were also recorded to see if any correlation could be found between these parameters and the eye findings. No significant difference in incidence was found in any of these areas except that all patients with serum cholesterol levels over 350 mgm.% had arcus senilis present. Their only positive correla-

tion was that the incidence of arcus senilis increases with advancing age.

### Bacteriuria in Pregnancy is Dangerous

The significance of asymptomatic bacteriuria in pregnancy is evaluated by Stuart, et al.[6] Their study confirms earlier work by Kass that there is a far higher incidence of prematurity in pregnant women who have asymptomatic bacteriuria. Increasing age and parity were also found to have positive correlation with pregnancy complication and renal disease. Certainly the significance of these studies will be confirmed if physicians can use such screening methods and, with proper antibiotic therapy, expand them to affect a decrease in the otherwise inevitable irreversible renal damage.

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# Blue Shield Performance by Type of Service

*(One of a series prepared by Indiana Blue Cross-Blue Shield)*

Our last article was an initial report on the 1964 Test of Performance Survey conducted by the National Association of Blue Shield Plans, and indicated that Indiana physicians and Indiana Blue Shield showed up well in this survey.

In Indiana—of the 15,000 questionnaires mailed—more than 80% were returned. This was slightly better than the national average. The survey showed that our best group certificate, most widely held group certificate and best non-group certificate all paid a higher percentage of the cost of physicians' service than the corresponding national averages.

A further analysis of the results of this survey are indicative of Indiana Blue Shield's ability to deal equitably with physicians and members in terms of type of service performed.

Our best group certificate paid 96% of charges for surgery, 97% of charges for anesthesia and 91% of medical charges. Our best group certificate is the county schedule approach, based upon the ISMA House of Delegates resolution #26.

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A study of all group business showed that Indiana Blue Shield paid 80% of charges for surgery, 73% of charges for anesthesia and 78% of medical charges.

Our best non-group certificate (preferred schedule) paid 83% of charges for surgery, 77% of charges for anesthesia and 80% of medical charges.

This data on Blue Shield performance in terms of type of service demonstrates forcefully that Indiana Blue Shield is not oriented toward any special class of physician or type of practice, but is doing a good job in its efforts to serve all members and all physicians on an equitable basis.

The analysis reveals Blue Shield's overall adaptability, flexibility and dependability in keeping pace with the ever-innovating practice of medicine. Most creditably, in instances where the Test of Performance results are less adequate, nearly all imbalances and inequities tend to disappear when the latest and best Blue Shield certificates are considered. ◄

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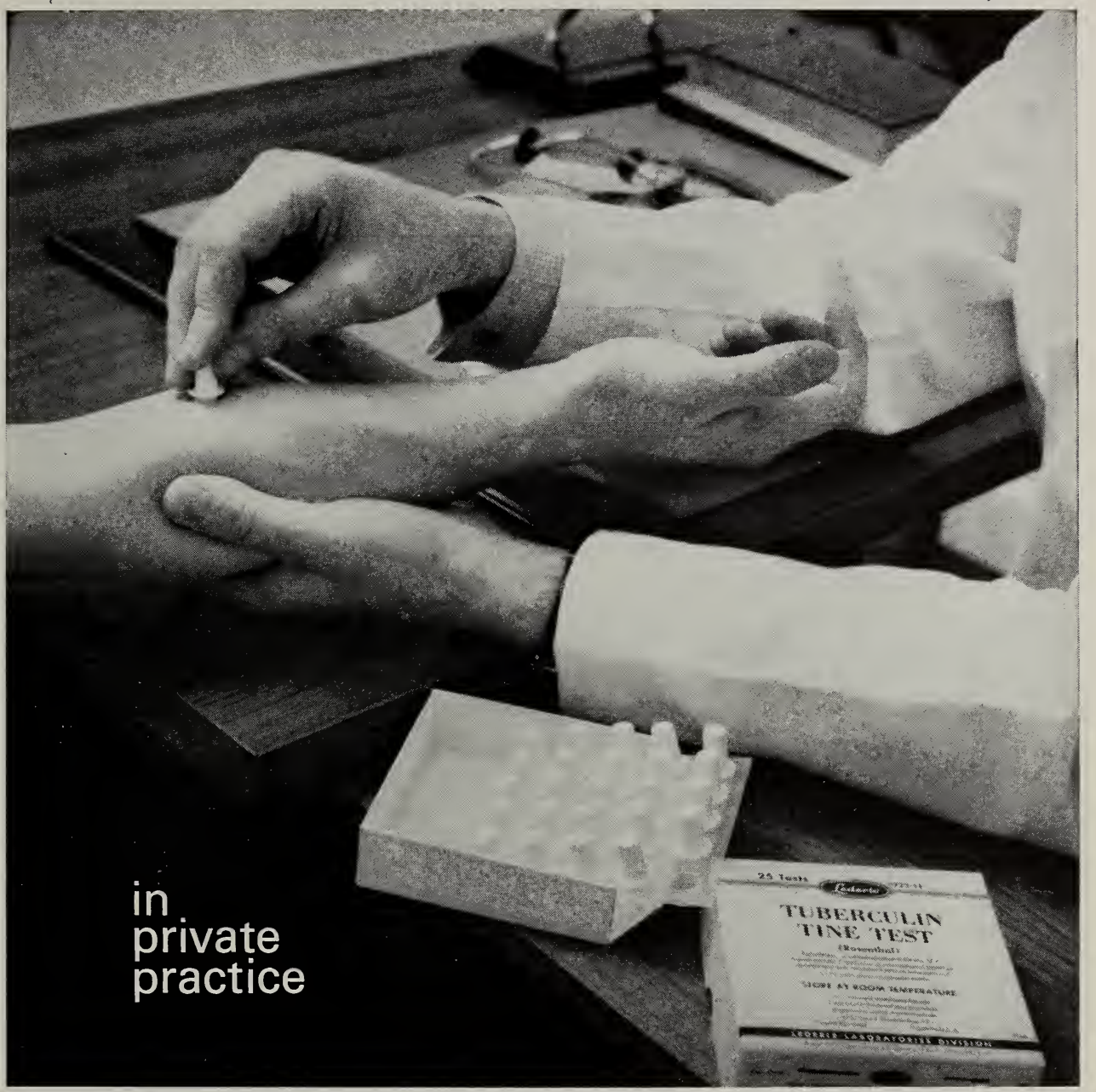
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*Medicine At Law*

# DECISIONS AND OPINIONS

**Highlights of recent court actions pertaining to health and medicine from *The Citation* prepared by the Law Division of AMA.**

*Medical Expert's Opinion Improperly Admitted Where Based on Information not in Evidence*—A trial court erred, in a suit for damages by a boy against a driver for injuries sustained when the driver's car allegedly ran over him, in admitting the opinion testimony of a physician who had examined him for the purpose of testifying, the Mississippi Supreme Court ruled. Part of the information on which he based his opinion was not in evidence in the case.

The physician's opinion was based in part on the history given him by the boy's mother, which included the assertion that he had been run over by an automobile. A trial court might, in its discretion, be justified in letting a medical expert base his findings in part on a history given him by a child's mother, but this would be limited to cases where the child was taken to the physician for treatment. Where the physician's examination is for the purpose of testifying, he should not be permitted to base his opinions and findings on such a history if it is not in evidence in the case, the court said.

The physician stated the opinion that the boy had received a compression fracture of the fifth vertebra. However, the x-rays taken at the time of his examination showed no fracture. He testified that his conclusion was based on the history given him by the mother and other physicians' x-rays and reports which he considered reliable. However those x-rays were not in evidence and none of the physicians on whose reports he relied testified. The opinion would have been admissible only if those x-rays and reports had been in evidence in the case, the court said.

*Wild v. Bass*, 173 So. 2d 647 (Miss., April 5, 1965).

*State not Liable for Suicide of Mental Hospital Patient*—No damages could be recovered in a suit against the state for the death of a mental hospital patient who committed suicide by jumping from a window in the fourth floor utility room. The room had been left unlocked for only a short period and the patient's suicide was not foreseeable, the New York Court of Claims ruled.

The window in the utility room had been broken. The workman sent to repair it entered the room, closed the door, and unlocked and opened the window bars to examine the broken glass. He decided that carpenter work was necessary to repair part of the window sash and went to the door and asked the nurse on duty in the ward to call the carpenter shop. When she decided the workman could explain the situation better himself, they both left the room, closing the door, and went a few steps to the telephone where he called the carpenter shop. Both the workman and the nurse testified that this took only a minute, that both had a view of the door during this time and that nobody left or entered. However, several minutes after he returned to the utility room, the workman discovered that the outside screen was hanging down and that the patient was on the ground below.

There was evidence that the patient had had suicidal tendencies, but that her exhibition of such tendencies had not been recent. She had had ample opportunity to commit suicide during her several escapes from the hospital. There was also evidence

that she had improved and was allowed certain ground privileges when visited by relatives. The patient had been out of the ward for two hours on the morning of her suicide taking recreation, and there was no explanation of how she could have learned or known that anything was being done about fixing the window or how she got into the utility room unobserved.

The case against the state here was not even as strong as the one in which, in refusing to hold the state liable, the Court of Appeals said, "An ingenious patient harboring a steady purpose to take his own life cannot always be thwarted." The patient here had no steady purpose to commit suicide, but did so because of an unexplained impulse. The state must repair its own hospital premises and a casual workman cannot be expected to always follow the rules to the letter. The patient's suicide was not reasonably foreseeable and the state was, therefore, not liable, the court said.

*Kates v. State of New York*, 261 N.Y. S.2d 988 (N.Y., Aug. 3, 1965).

*Physician Liable Because of Failure to Warn Patient of Dangers of Gold Injections* —A patient who developed exfoliative dermatitis as the result of a series of injections by a physician of a gold compound in treating her for rheumatoid arthritis was entitled to recover damages in a suit against him. A judgment entered on a jury verdict in favor of the patient was affirmed by a New York intermediate appellate court.

The evidence established that the possibility of undesirable reactions in the use of gold therapy was recognized by the medical profession and that no immediate emergency existed with respect to the treatment of the patient's condition. Under the circumstances, the physician had the duty of making a reasonable disclosure to the patient of the known dangers incident to or possible in the proposed use of gold. Therefore, the trial court did not err in instructing the jury that the physician could be found guilty of professional negligence if he failed in that duty. The physician contended that the evidence on the question of the failure to disclose the treatment's possible dangers was not within the allegations


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of the pleadings. Since there was no objection to the evidence on that ground when it was offered, its admission did not furnish grounds for reversal, the court said.

*Di Rosse v. Wein,* 261 N.Y.S.2d 623 (N.Y., June 28, 1965).

*No Cause of Action Stated by Physician's Third-party Complaint Against Hospital*—A physician's third-party complaint against a hospital, by which he sought to implead it in a suit for damages against him for the death of a patient allegedly caused by an infection which resulted from the leaving of a sponge in the patient's hip during an operation, was dismissed by a New York trial court. The third-party complaint failed to state a cause of action against the hospital.

In his third-party complaint, the physician alleged that he was entitled to indemnity from the hospital because the nurses it furnished were actively negligent in having failed to keep an accurate account of the sponges and pads used in the operation and in reporting, after the operation, that all sponges and pads used had been accounted for.

A claim against a third party charging him with active negligence will be allowed if the original complaint can reasonably be interpreted as including an allegation of passive negligence on the part of the one against whom the original complaint was filed. However, impleader is improper if the original complaint alleges that the one against whom it was filed was guilty of only active, as distinguished from passive, negligence, because an actively negligent tortfeasor is not entitled to indemnity. The custom in the practice of surgery of having attending nurses account for sponges before and after an operation is reasonable and wise. However, that custom does not relieve a physician of his affirmative duty of making a reasonable and careful examination, before closing an incision, to determine whether anything has been left in the patient's body, the court said. The original complaint clearly charged the physician with active negligence in having failed to discharge the affirmative duty of making such an inspection. Therefore, his third-party complaint against the hospital failed to state a cause of action, because, if he should be found guilty of the active negligence alleged in the original complaint, he would not be entitled to indemnity from the hospital.

*Blau v. Levine,* Sup. Ct., Kings Co., N.Y. Law Journal (N.Y., July 23, 1965). ◄


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William E. Fitzkee, 167 S. Main St., Mount Wolf, Pa.

### SPECIALISTS

Jean Ann Stieglitz, 4940 E. End Ave., Chicago, Ill. 60615—*Anesthesiology*

Quincy R. Hauss, 1432 Lebanon Ave., Belleville, Ill.—*Anesthesiology*

Julian Allen, 6019 Montrose, Chicago, Ill. 60634—*Ear, Nose and Throat*

Claude A. Gianetto, 818 12th Ave., Coralville, Iowa —*Internal Medicine*

Ronald B. Massarik, U. S. Army Hospital, Fort Jackson, S. C.—*Internal Medicine*

Atanasio Fajardo, 24776 Currier St., Dearborn Heights, Mich.—*Internal Medicine*

Melvin L. Hirsch, Country Club Apartments 5-B, Augusta, Ga. 30904—*Internal Medicine*

John E. Dymond, 34715 Nancy, Wayne, Mich.—*Internal Medicine* (*Rheumatology*)

David K. Davoudlarian, 3822 N. Braeswood Blvd., Apt. 114 Houston, Texas 77025—*Ob-Gyn*

Richard Marchick, 7308 Amherst Ave., St. Louis, Mo. 63130—*Ob-Gyn*

John S. Spangler, 1929 N. Senate Ave., Indianapolis, Ind. 46202—*Ob-Gyn*

George R. Petrie, Jr., Box 242, R. D. 1, St. Matthews Rd., Chester Springs, Pa.—*Ob-Gyn*

Robert Littlejohn, 6029 Catalina, Mission, Kan.—*Orthopedics*

Cornelius E. Healy, 253 Dickman Dr., Oring AFB, Maine 04750—*Pediatrics*

Vasile L. Krausz, Middlesex General Hospital, New Brunswick, N. J.—*Psychiatry*

Steve C. Cuff, Illinois Masonic Hospital Association, 836 Wellington Ave., Chicago, Ill.—*Radiology*

Charles E. Lavis, 7805 Willow St., New Orleans, La.—*Radiology*

Jerry M. Hardacre, 188 Fairway Dr., Columbus, Ohio 14—*General Surgery*

James L. Doerr, 6914 Greenspan, Dallas, Texas 32 —*General Surgery*

James D. King, U. S. Naval Hospital, Bainbridge, Md. 21905—*General and Thoracic Surgery*

Robert A. Prots, 25250 Benesch Dr., Cleveland, Ohio 44122—*General Surgery*

Robert G. Collier, 529 S. Governor St., Iowa City, Iowa—*General Surgery*

Francisco D. Avellana, Block 7, Lot 8, Tacloban, Philippines—*General Surgery*

Gary R. Alford, R. # 2, Blue Bill Park Dr., Waunakee, Wis. 53597—*Urology*

Floyd R. Overby, 505 5th Ave. South, Hopkins, Minn.—*Urology*

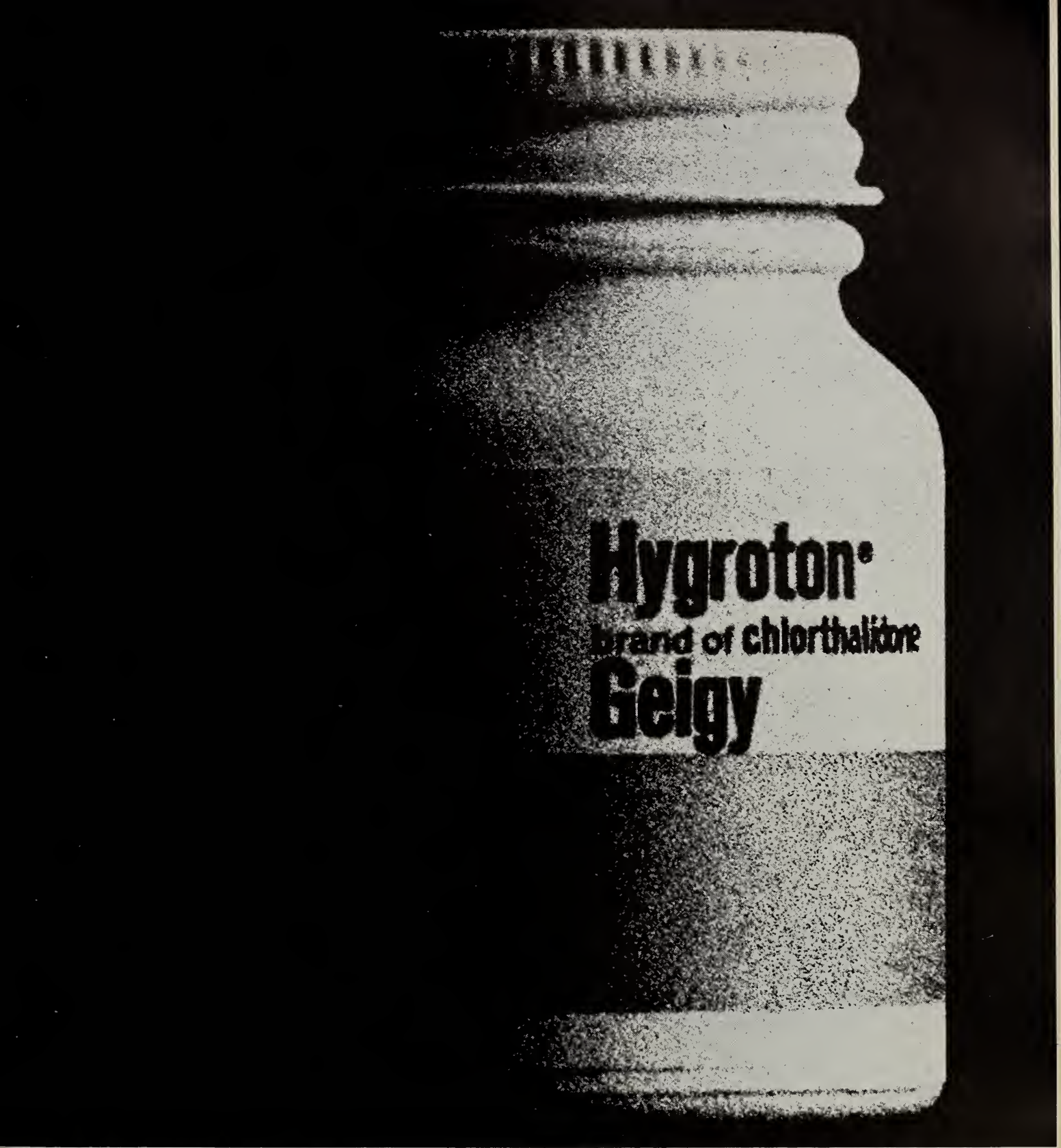
Continued

**Description:** Hygroton, brand of chlorthalidone, is an oral diuretic agent of value in the treatment of edema and hypertension. The drug is notable for its prolonged action (48-72 hours) and low toxicity. It is not a thiazide and may often be employed successfully in patients who are intolerant of other agents or become refractory to them.
**Indications:** Hypertension and many types of edema involving retention of salt and water.
**Contraindications:** Hypersensitivity and most cases of severe renal or hepatic disease.
**Warning:** With administration of enteric-coated potassium supplements, the possibility of small bowel lesions should be kept in mind.
**Precautions:** Reduce dosage of concomitant antihypertensive agents by at least one-half. Discontinue if the BUN rises or liver dysfunction is aggravated. Electrolyte imbalance and potassium depletion may occur; take special care in cirrhosis or severe ischemic heart disease, and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.
**Side Effects:** Agranulocytosis, constipation, dizziness, dysuria, headache, hyperglycemia, hyperuricemia, impotence, leukopenia, muscle cramps, nausea, postural hypotension, purpura, thrombocytopenia, transient myopia, urticaria, vomiting and weakness.
**Average Dosage:** One tablet (100 mg.) daily with breakfast.
**Availability:** Tablets of 100 mg. in bottles of 100 and 1000. For full details, see the complete prescribing information.

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2521 Fairfield, Fort Wayne, Ind. 46807
416 N. Main St., Evansville, Ind. 47711


## WANTED

Continued

### SPECIALISTS

Harry J. Weber, Grant Memorial Hospital, Petersburg, W. Va.—*Surgery*

Velda J. Weber, Grant Memorial Hospital, Petersburg, W. Va.—*Anesthesiology* (Husband and wife team)

### ADDITIONAL LOCATIONS

Huntington County—WARREN—Opening for a physician for the Methodist Memorial Home, completely owned and controlled by the North Indiana Conference of the Methodist Church. Present membership 375. More than 160 rooms in the hospital section of the home. Salaried position. For further details write Dr. D. C. Sounder, Executive Secretary, Warren, Ind. ◄




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# ABSTRACTS

## BOOK REVIEWS

### HANDBOOK OF CLINICAL LABORATORY DATA

Henry C. Damm, Chemical Rubber Co., Cleveland, Ohio, 1965, $15.00.

This text collects into one reference a wide range of data related to clinical and anatomical pathology. The fields of clinical chemistry, toxicology, hematology, blood banking, microbiology, and general anatomical pathology are covered. Discussions giving basic principles and interpretation of laboratory determinations such as catecholamines, pregnanetriol, aldosterone, porphobilinogens and many other commonly used and newer tests are taken up. Sections on automation, chromatography, electrophoresis and quality control are also included.

Charts and tables are abundant, enabling a wide scope of material to be included in the 469 pages. The charts of normal values are especially helpful to the practitioner who must interpret the continuing number of new tests available. Information describing procedures for obtaining and handling cultures for virus, fungi and bacteria is very helpful.

As with almost all first editions, there are occasional errors such as the weights of the pineal and parathyroid glands being given in grams instead of milligrams.

The book is well bound and compact for the amount of information. The text is a valuable reference for physicians, medical technicians and other persons dealing with biological sciences.

JAMES J. SULLIVAN, M.D.
Indianapolis

### Tracy's: THE DOCTOR AS A WITNESS

Wm. J. Curran, LL.M., 2d ed., W. B. Saunders Company, Philadelphia, Pa., 1965; 196 pages, $5.75.

Because the first edition filled so well a very specialized need, this second edition appears a mere eight years later.

Simple, non-legal language expounds to the doctor exactly what the title promises: his obligations and his rights when appearing in court: what TO say, what NOT to say.

Fortunately for most of us, our court appearances are not a weekly event. Yet, when the need arises, this is just the book the doctor should peruse the night before the scheduled day.

The printing and binding are good; I noted no typographical errors; the price is in line with the usual. Mr. Curran and the publishers deserve praise for their efforts. This monograph belongs on the shelves of every hospital library and clinic.

ARNOLD LIEBERMAN, M.D.
New York, N.Y.

## Abstracts From Various Literature, Prepared by AMA

### SMALL BOWEL OBSTRUCTION DUE TO PHYTOBEZOAR IN GASTRECTOMIZED SUBJECTS

J. J. Y. Chun and J. J. Dinan (5300 Cote des Neiges Rd., Montreal)

*Canad. J. Surg.* 8:272, (July), 1965.

"Phytobezoar" obstruction in the small bowel due to vegetable cellulose material and the pith of citrus fruits is of importance in the diagnosis of patients with acute abdominal symptoms. An increasing incidence of this condition has been reported recently, especially in postgastrectomy patients; it is more common after the Billroth II type of procedure. The absence of normal pyloric function, subnormal milling effects of the gastric peristalsis, and the diminished gastric secretion in association with improper mastication due to poor dentures are believed to be some of the contributing factors in this type of intestinal obstruction. Preoperative diagnosis is rather difficult, since the clinical signs and symptoms are similar to those of other types of bowel obstruction. Recognition of predisposing factors like (1) the type of food taken, (2) previous gastrectomy, (3) presence of poor dentures and poor eating habits may lead to

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correct preoperative diagnosis. In case of doubt, laparotomy is indicated. Dietary advice and better dental care in postgastrectomy patients may prevent this type of intestinal obstruction.

## EFFECTS OF ACETYLSALICYLIC ACID, PHENACETIN, PARACETAMOL, AND CAFFEINE ON RENAL TUBULAR EPITHELIUM

L. F. Prescott (University of Aberdeen Medical Bldg., Foresterhill, Aberdeen, Scotland)
*Lancet* 2:91-95, (July 17), 1965.

The excretion of renal tubular cells, erythrocytes, and leukocytes was measured in 70 healthy volunteers before and during the administration of aspirin, the combination of aspirin, phenacetin, and caffeine (APC), phenacetin, n-acetyl-p-aminophenol (Paracetamol), caffeine, or placebo. Ten volunteers receiving 3.6 gm of aspirin daily, all showed a striking increase in the output of renal tubular cells and erythrocytes. Similar but less notable changes were seen in five of ten volunteers given APC (1.8 gm aspirin, 1.8 gm phenacetin, and 1.2 gm caffeine). For the first time, the nephrotoxic effects of phenacetin and caffeine were demonstrated in healthy volunteers. Two of ten volunteers taking 3.6 gm phenacetin daily showed a great increase in renal-tubular cell excretion while the administration of 2.4 gm caffeine citrate daily resulted in a moderate increase in mean renal tubular cells and erythrocytes in another 10. There was only a slight increase in mean renal-tubular cell excretion in 21 volunteers given 3.6 gm n-acetyl-p-aminophenol daily. No significant change occurred in 10 given placebo tablets. None of the drugs tested seemed to influence the output of leukocytes or urinary protein. It is suggested that nephritis following the use of analgesics is caused by the abuse of several different drugs and not by phenacetin alone.

## AIRBORNE BACTERIAL CONTAMINATION

H. R. Bernard et al. (4960 Audubon, St. Louis)
*Arch. Surg.* 91:530, (Sept.), 1965.

The number of airborne bacteria arising from a human being wearing an operating room scrub suit increases remarkably after shower bathing. The effect is most pronounced between 10 and 45 minutes after showering and usually ceases within one to two hours. Bacteria arising from the nasopharynx contribute a small fraction of the total shed into the environment. The increase in bacterial shedding caused by shower bathing may be abolished, and the number of bacteria ordinarily shed may be reduced by (1) application of 70% ethyl alcohol or lanolin to the skin or (2) by clothing the subject in a one-piece suit of a tightly woven fabric. Application of these principles may be of practical importance in relation to the treatment of patients who are unusually susceptible to bacterial infection. ◄

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# INDIANA STATE BOARD OF HEALTH

## MONTHLY REPORT—October, 1965

| Disease | Oct. 1965 | Sept. 1965 | Aug. 1965 | Oct. 1964 | Oct. 1963 |
|---|---|---|---|---|---|
| Animal Bites | 711 | 1144 | 890 | 896 | 692 |
| Chickenpox | 85 | 46 | 38 | 205 | 107 |
| Conjunctivitis | 89 | 105 | 127 | 124 | 23 |
| Diphtheria | 0 | 0 | 0 | 0 | 1 |
| Dysentery, Unspecified | 46 | 116 | 89 | 237 | 81 |
| Gonorrhea | 347 | 345 | 357 | 262 | 308 |
| Impetigo | 224 | 262 | 244 | 198 | 172 |
| Infectious Hepatitis | 35 | 42 | 43 | 43 | 43 |
| Infectious Mononucleosis | 43 | 63 | 27 | 47 | 16 |
| Influenza | 739 | 543 | 194 | 911 | 382 |
| Measles (Rubeola-Rubella) | 212 | 86 | 123 | 158 | 123 |
| Meningitis, Meningococcal | 4 | 2 | 1 | 4 | 2 |
| Meningitis, Other | 7 | 2 | 5 | 8 | 8 |
| Mumps | 60 | 58 | 70 | 173 | 139 |
| Pertussis | 4 | 17 | 11 | 50 | 21 |
| Pneumonia | 329 | 260 | 112 | 242 | 87 |
| Poliomyelitis | 0 | 0 | 0 | 2 | 0 |
| Streptococcal Infection | 462 | 549 | 321 | 497 | 291 |
| Syphilis | | | | | |
| Primary & Secondary | 6 | 5 | 3 | 9 | 7 |
| All Other Syphilis | 65 | 97 | 88 | 118 | 168 |
| Tinea Capitis | 5 | 21 | 7 | 47 | 9 |
| Tuberculosis (Active) | 96 | 82 | 114 | 120 | 111 |


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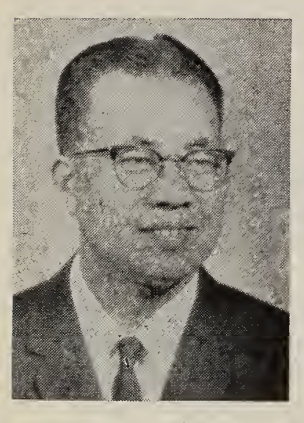
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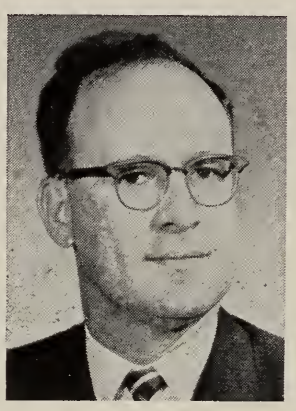



## DOCTORS LOH AND HALEY ELECTED TO THE JOURNAL EDITORIAL BOARD

Dr. Wei-Ping Loh, Gary, has been elected to the Editorial Board of *The Journal* for a three-year term.



Dr. Loh



Dr. Haley

Dr. Loh, a regular contributor to *The Journal's* "Path-finder" and "Laboratory Medicine" pages, is Chief Pathologist and Director of Laboratories at Methodist Hospital of Gary, Inc., a position he has held since 1961. He is Assistant Professor of Pathology at the Chicago Medical School and will become Associate Professor of Pathology there next year.

Dr. Loh is a Fellow of the American College of Physicians and of the College of American Pathologists.

Dr. Alvin J. Haley, Fort Wayne general practitioner, was re-elected to a three-year term on the board.

## *Indiana Physicians Named Fellows Of American College of Surgeons*

Fourteen Indiana physicians have been named Fellows of the American College of Surgeons. Ceremonies were held in Atlantic City, N. J.

The new Fellows are: Drs. S. Rahim Farid, Brazil; F. Bruce Monroe, Crown Point; Philip S. Zeitler, Elkhart; Frederic W. Brown and Charles S. Griffin, Fort Wayne; Leo Roth, Gary; Rodolfo M. Madlang and Kenneth O. Fetrow, Hammond; John P. Baxter, Irvin L. Heimburger and Kingsley Lawrance, Indianapolis; William G. Moore, La-Porte; Ignacio B. Castro, Jr., Scottsburg and Paul D. Johnson, Jr., Terre Haute.

## Dr. Pratt Volunteers

Ralph M. Pratt, Jr., Madison, has volunteered to serve in Project Viet-Nam.

Dr. Pratt, graduated from the Indiana University School of Medicine in 1955, served his internship at Indianapolis General Hospital. He has been a member of the association since 1956 and is a general practitioner.

## *University of California Lists New Fellowship Programs Available*

The University of California School of Public Health at Berkeley has training programs of interest to physicians for which fellowships are available. Applications are now being accepted for the courses starting in September, 1966.

Basic Training in Maternal and Child Health, Training in School Health, Training in Mental Retardation and Related Conditions, Training in Family Planning and a Combined Pediatric course are offered. If interested write Dr. Helen M. Wallace, Earl Warren Hall, Berkeley, California.

## Dr. Baxter Named President

Dr. Neal E. Baxter, Bloomington, has been elected president of the Aerospace Medical Association. Dr. Baxter was a U. S. Naval Flight Surgeon during World War II.

He has been Federal Aviation Medical Examiner since 1947, and has been a member of the Medical Advisory Committee to the Federal Air Surgeon and of the AMA Committee on Aerospace Medicine.

## *Louisiana State Medical Society Solicits Donations to "Betsy Fund"*

The Louisiana State Medical Society is soliciting contributions to a "Betsy Fund" to aid physicians whose offices and homes were totally destroyed by Hurricane Betsy.

Dr. Charles B. Odom, president of the society, said, "We already know of three members of our society residing in areas below New Orleans who were completely wiped out by the hurricane. The purpose of the Louisiana State Medical Society Betsy Fund is to assist these physicians in getting reestablished as quickly as possible."

Flood losses, which caused the greatest damage to the offices and homes of these physicians, are not covered by insurance.

The Louisiana State Medical Society has already made cash grants to some of the physician hurricane victims and will distribute all of the proceeds of the Betsy Fund as quickly as possible.

All physicians are invited to contribute. Checks should be made to the Louisiana State Medical Society Betsy Fund, Room 1528, 1430 Tulane Ave., New Orleans, La. 70112.

## New Sales Training Manager

George Garrett, who has been a sales representative for Pitman-Moore since 1954 has been appointed as their sales training manager. He will live in Indianapolis and will train and develop the Pitman-Moore sales force.

## *Sample Agreement for Operation Of Emergency Department Available*

A sample agreement for the operation of a hospital emergency department by a partnership of physicians on the medical staff has been prepared by the American Medical Association.

Copies of the agreement may be obtained by writing Department of Hospitals and Medical Facilities, AMA, 535 N. Dearborn St., Chicago 60610.

## Medical Assistants Trustee

Mrs. Marie Young of Indianapolis was elected to a three-year term as trustee of the American Association of Medical Assistants at a recent meeting in New York City, the occasion of the organization's annual convention.

## *Indiana Physicians Win National Pathology Awards*

Both the $1,000 scholarships provided by Warner-Chilcott Laboratories and awarded by the American Society of Clinical Pathologists were won this year by Indiana physicians.

Dr. Paul D. Gard, Jr., a native of Huntington, has practiced at Bogalusa, Louisiana and is now studying pathology at the Kentucky Medical Center, Lexington, Kentucky. Dr. David D. Aldrich, a native of Indianapolis and a graduate of I.U. School of Medicine is now in a residency in pathology at Indiana University Medical Center. The fellowships are awarded for the purpose of encouraging outstanding students in the practice of pathology.

## Dr. Barbara Backer Honored

Dr. Barbara Backer of LaPorte has been listed in the latest edition of "Outstanding Young Women of America," an annual biographical compilation of 6,000 outstanding young women between the ages of 21 and 36.

Dr. Backer is a graduate of Indiana University School of Medicine and pursued postgraduate training in internal medicine. She is active in many community and health organizations in LaPorte.

## *Nurses Education Program Announced by Indiana University*

Indiana University has announced its collaboration with the Methodist Hospital of Indianapolis in the conduct of a two-year nurses' education program which will lead to an associate of arts degree in nursing.

The I. U. Downtown Campus in Indianapolis will be utilized for didactic instruction; clinical nursing experience will be acquired at Methodist Hospital. The hospital will discontinue its three-year diploma school when the presently enrolled students have graduated, but will continue its four-year baccalaureate program in association with DePauw University.

## William Osler Medal Student Essay Contest Is Announced

The William Osler Medal of the American Association for the History of Medicine is awarded annually for the best unpublished essay on a medico-historical subject written by a student in one of the medical schools in the United States or Canada. All students who are candidates for the degree of Doctor of Medicine, or who graduated in 1965, are eligible. This medal, first awarded in 1942, commemorates the great physician, Sir William Osler, who stimulated an interest in the humanities among students and physicians alike.

Essays should demonstrate either original research or an unusual appreciation and understanding of a medico-historical problem. Maximum length is 10,000 words. The prize-winning essay will be submitted to the editorial committee of the association, which may recommend it for publication in the *Bulletin of the History of Medicine.*

Essays must be submitted by March 23, 1966, to the Chairman of the Osler Medal Committee, William K. Beatty, Librarian and Professor of Medical Bibliography, Northwestern University Medical School, 303 E. Chicago Ave., Chicago, Illinois 60611. ◄

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# *Annual Meeting Dates of Professional Medical and Allied Organizations*

**AMERICAN MEDICAL ASSOCIATION CLINICAL CONVENTION**
Date Nov. 28—Dec. 1, 1965
Place Philadelphia, Pa.

**INDIANA STATE MEDICAL ASSOCIATION CONVENTION**
Date October 10-13, 1966.
Place French Lick, Indiana

**INDIANA ACADEMY OF GENERAL PRACTICE**
Date May 3-5, 1966
Place Fort Wayne

**INDIANA NEUROPSYCHIATRIC ASSOCIATION**
Date Second Wednesday of every month, October through May
Place The Athenaeum, Indianapolis

**INDIANA ACADEMY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY**
Date May 4-5, 1966
Place French Lick Sheraton Hotel, French Lick

**NORTHERN INDIANA PSYCHIATRIC SOCIETY**
Date Fourth Wednesday of every month, September through June
Place For location and program, inquire Beatty Memorial Hospital, Westville





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**Precautions:** Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

**Side effects:** Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

**Usual adult dosage:** One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

**Supplied:** In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

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# FUTURE MEETINGS, SEMINARS, COURSES

## *Ophthalmology and Otolarygology Academy Sets 19th Annual Meeting*

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 19th annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia on April 13-16, 1966.

A registration fee of $35 for associate members will cover all social and scientific sessions. For additional information, please contact the secretary, J. Elliott Blaydes, Jr., M.D., First National Bank Building, Bluefield, West Virginia.

## Cleveland Clinic Announces Four Postgraduate Courses

The Cleveland Clinic Educational Foundation will present four postgraduate courses next month at Cleveland. First will be a postgraduate course in "Ophthalmology" on January 12-13; second is one on "Vascular Surgery" set for January 19; "Biliary and Pancreatic Surgery" will be offered January 20 and "Advances in Pediatrics" on January 26-27.

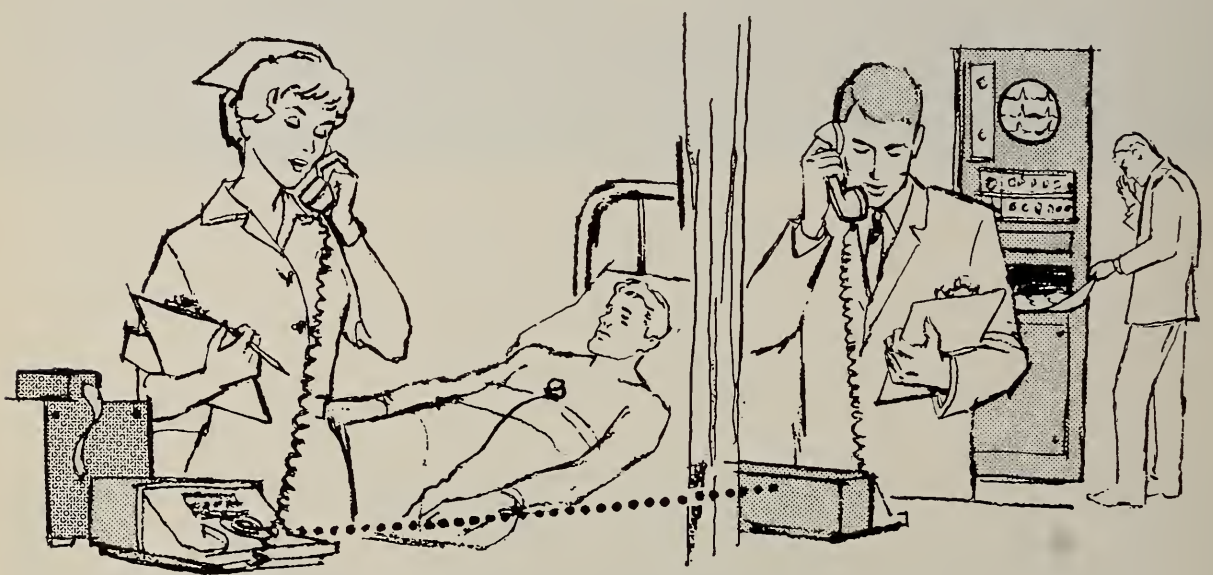
Registration fee for each course is $30.00. Further information and detailed programs may be obtained from the Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland 44106.

## *Ski Vacation, Scientific Meetings Combined by Colorado Medical*

Winter ski vacation and scientific meetings have been combined in the plans for the 31st midwinter clinical session of the Colorado Medical Society. Headquarters for the program scheduled March 1 through 3 will be the Brown Palace Hotel in Denver, Colorado. Chartered buses will provide transportation for ski enthusiasts to go to Winter Park in the Rocky Mountains March 4 for a day's skiing, with lunch planned at the picturesque Hocklandhof.

New this year will be a cocktail party Tuesday evening March 1 at the Brown Palace, for doctors and their ladies to renew acquaintances and meet new friends. The annual midwinter dinner-dance will be held at the Brown Palace on Wednesday evening, March 2.

At the Wednesday morning program a panel of nationally recognized experts will discuss the Medicare law. The roundtable luncheon will afford an opportunity for questions and answers with the morning's participants.

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The Thursday morning program will be held at Children's Hospital in Denver. The roundtable luncheon following at the Brown Palace Hotel will offer a question and answer period concerning the morning's presentations.

Tuesday and Thursday afternoon, the society's House of Delegates will hold its midwinter meetings. All doctors are welcome to attend open sessions of the house meetings as well as scientific programs. A $5.00 registration fee is charged all doctors of medicine. Interns and postgraduate residents properly accredited by their hospital superintendents are welcome to attend without charge.

Additional details about the scientific sessions and 31st-meeting ski holiday may be obtained by writing the Colorado Medical Society, 1809 E. 18th Ave., Denver, Colorado 80218.

## History of Medicine Society Will Meet in Indianapolis in January

The first meeting of the John Shaw Billings History of Medicine Society will begin at 6:30 p.m. January 12, 1966 at the Indiana State Teachers' Association building.

Professor Leo M. Zimmerman of Chicago will speak on "Medical Reflections in Art" at this organizational meeting. The meeting is open to all persons interested in the history of medicine. For further information and dinner reservations, please write John B. Stetson, M.D., Indiana University Medical Center, Indianapolis, Ind. or phone 635-7387. Dinner reservations must be made in advance. A cash bar will open at 6:30, the dinner will be at 7:30 and the speaker at 8:30 p.m.

## *Members of ISMA Invited to Conference on Anesthesiology*

Members of ISMA are invited to attend the Third Annual Midwest Conference on Anesthesiology to be held at the Continental Plaza Hotel in Chicago on April 28 to 30, 1966.

The program will include presentations of interest to anesthesiologists, physician anesthetists, nurse anesthetists and surgeons. For further details write Dr. T. L. Ashcraft, 33 E. Cedar St., Chicago 60611.

## University of Colorado Sets 1966 "General Practice Review"

The University of Colorado has set a "General Practice Review" for January 16-22, 1966, as part of its postgraduate medical education program.

Further information and a complete program may be obtained from the Office of Postgraduate Education, University of Colorado School of Medicine, 4200 E. Ninth Ave., Denver, Colo. 80220. ◄





11:47 pm 11:53 pm 12:06 am

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke TRADE-MARK®

# County, District News

### Thirteenth District

Dr. James Hurley, Elkhart, is the new president of the Thirteenth District. Other officers elected were: Drs. Gordon Cook, South Bend, vice-president; Cecil Burket, Bremen, secretary-treasurer and Otis R. Bowen, Bremen, councilor.

### Allen

Dr. Adolph B. Loveman, of the University of Louisville, was guest speaker at the Oct. 5 meeting of the Allen County Medical Society. His topic was "Common Dermatologic Problems."

### Clark

A discussion on high school athletic and gymnastic physical examinations highlighted the Oct. 26 meeting of the Clark County Medical Society. There were 27 members present.

### Clinton

"Allergies" was the topic chosen by Dr. Kenneth L. Craft, Indianapolis, when he spoke before the Oct. 26 meeting of the Clinton County Medical Society.

### Dearborn-Ohio

Dr. Murl Fox, a veterinarian, showed slides of a trip to Russia and Poland to the Oct. 7 meeting of the Dearborn-Ohio County Medical Society. There were 30 doctors and their wives present.

### Owen-Monroe

Dr. Edward F. Steinmetz, Indianapolis, discussed "Cardiac Resuscitation" with the 30 members of the Owen-Monroe County Medical Society present at the Oct. 28 meeting.

### Wayne-Union

The Wayne-Union County Medical Society met Oct. 12 to hear Dr. Gary Gish, Ph.D. from the University of Kansas, speak on "Pulmonary Physiology." Thirty-one members attended.

### Whitley

A movie and discussion on "Disaster Planning" by Dr. John Wilson, Columbia City, highlighted the Oct. 12 meeting of the Whitley County Medical Society. Eleven members attended the meeting. ◄


# THE HARDING HOSPITAL

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A fully accredited private psychiatric hospital situated on 45 acres of beautiful, wooded grounds just ten miles north of the state capitol.

**THE HARDING HOSPITAL PROVIDES:**

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*Medical Director*

James L. Hagle
*Administrator*

# DOCTOR'S HOUSE CALL



**Monday through Friday**
**7:25 A.M. and 4:25 P.M.**

Twice each day, Monday through Friday, Dr. James Rogers Fox discusses a variety of important medical questions. Using brief and simple explanations, Dr. Fox will answer many of the questions so important in our day-to-day living.

*Sponsored by:*

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# Deaths

### Walter A. Foreman, M.D.

Dr. Walter A. Foreman, a physician at Brookville since 1935 and Franklin County coroner from 1950 to 1962, died Oct. 30 in Mercy Hospital, Fairfield, Ohio. He was 70.

Dr. Foreman, graduated from the Indiana University School of Medicine in 1925, was a veteran of World War I and a member of the Fayette-Franklin County Medical Society.

### John D. Garrett, M.D.

Dr. John D. Garrett, retired Indianapolis specialist, died Oct. 11 in Johnson County Memorial Hospital at the age of 93.

Graduated from Northwestern University School of Medicine, Dr. Garrett was a general practitioner in Indianapolis for some years and then became an eye, ear, nose and throat specialist late in his career. He had retired less than a year ago from the practice of medicine. Dr. Garrett was a member of the ISMA 50-Year Club, a Senior Member of ISMA and a member of the Marion County Medical Society.

### Walter A. Stauffer, M.D.

Dr. Walter A. Stauffer, 88, who practiced medicine in Elkhart for over 50 years, died there Sept. 15.

Dr. Stauffer was graduated from Northwestern University School of Medicine in 1904. He returned to Elkhart, his birthplace, and practiced medicine there until his retirement in 1960. He was a Senior Member, member of the Elkhart County Medical Society and the 50-Year Club.

### Stanford Sweany, M.D.

Dr. Stanford Sweany, Munster physician, was killed Oct. 24 when his small plane crashed in Upper Michigan. He was 48 years old.

Dr. Sweany, a specialist in internal medicine and chest diseases, was graduated from the University of Chicago Medical School in 1943. He was a member of the Lake County Medical Society. ◄

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## Pick Most Competent Detailman

Have you ever wanted to pass along a compliment about a drug company representative? Would you like to let his boss know that he has been especially helpful? Here's your chance. We want to find out the most popular, most helpful detailman in the state of Indiana. We want to recognize his service to medicine and in recognizing him, express appreciation to all these men who, in the proper fulfillment of their duties, are a real service to Indiana medicine. Please drop in an envelope and mail to *The Journal*, ISMA, 3935 N. Meridian St., Indianapolis, Ind. 46208.

I vote for the below named man (men) whom I consider the most helpful drug company representative (s) now calling on me. (Name as many as three)

| Name of detailman | Company |
|---|---|
| | |
| | |

Remarks, if any:

Your name (optional)



# *1965—The Convention Story*



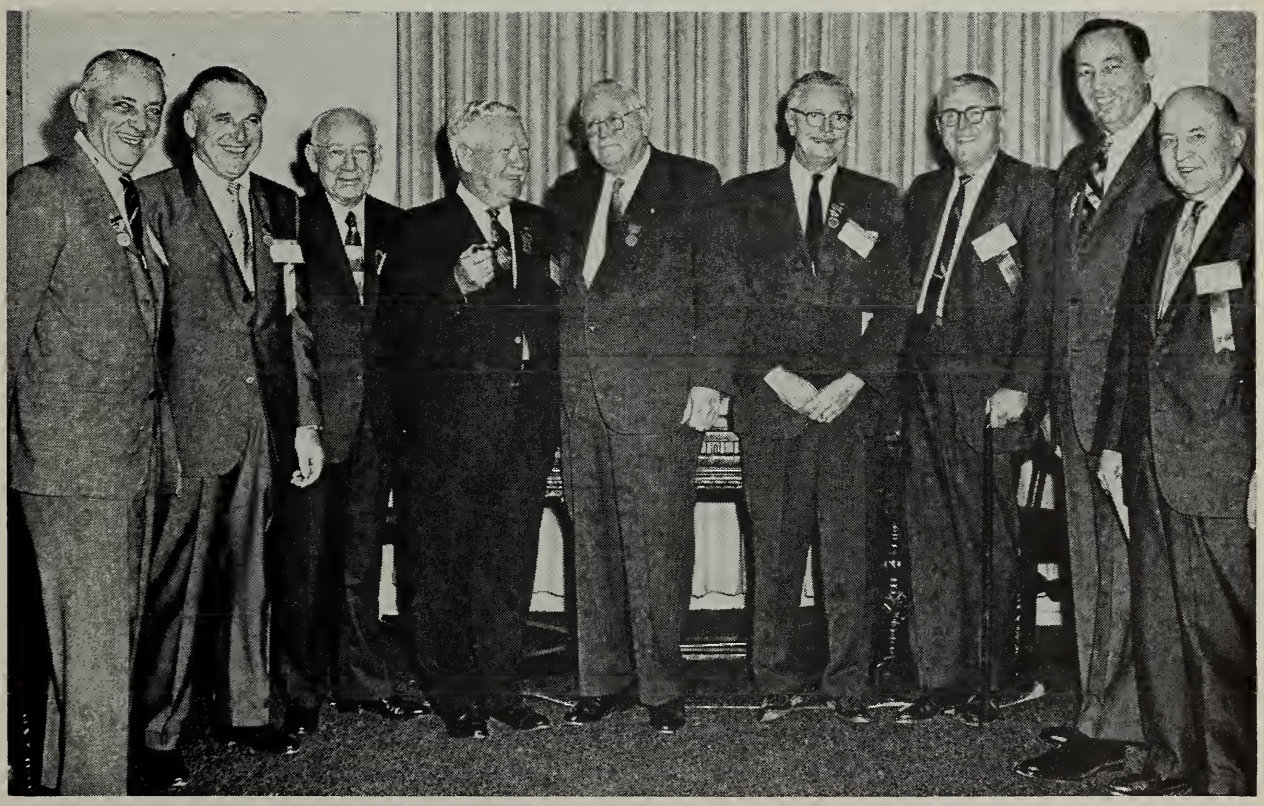

**TECHNICAL EXHIBITORS** spent many hours extolling the merits of their products.



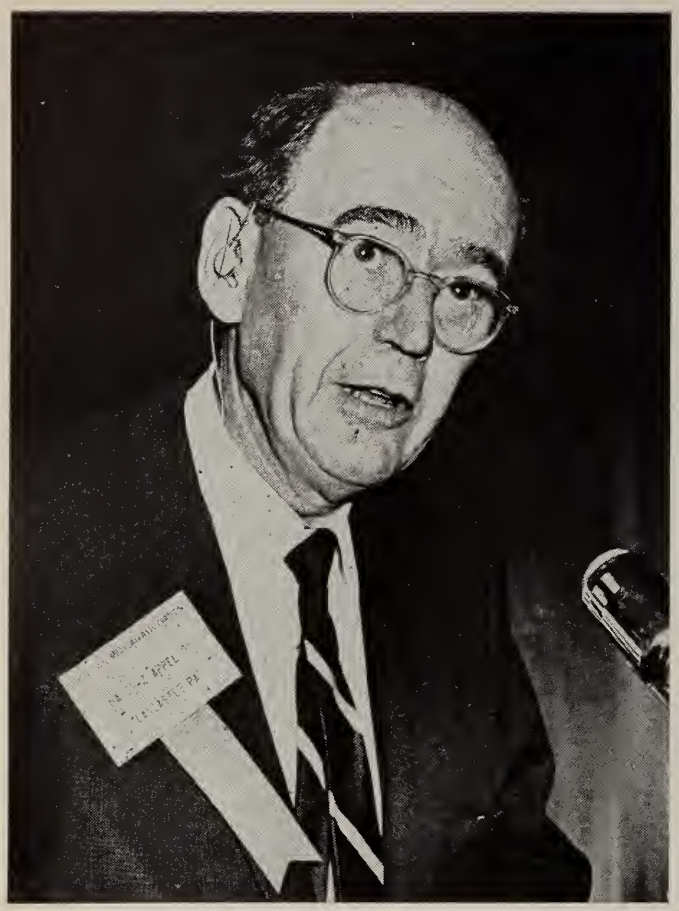
**HOUSE OF DELEGATES** members listen attentively to the proceedings of their first meeting Monday night in the Ballroom of the Columbia Club.



**REGISTRATION** began Monday morning, with the usual crowds lined up to "sign in."



**THE PAST PRESIDENT'S LUNCHEON** Tuesday brought together many of the association's former presidents. Shown at the luncheon this year are (left to right) Drs. Guy A. Owsley, Hartford City; Don E. Wood, Indianapolis; Herman M. Baker, Evansville; William Harry Howard, Hammond; Karl R. Ruddell, Indianapolis; M. C. Topping, Terre Haute; Maurice Glock, Fort Wayne; Joe M. Black, Seymour and Earl Mericle, Indianapolis.



DR. JAMES Z. APPEL, president of the AMA, was the speaker at the first joint scientific meeting of ISMA and the AMA Congress on Occupational Health Tuesday.



MEMBERS of the Editorial Board met Tuesday for their annual luncheon. Shown (left to right) are Drs. Harold Lynch, A. W. Cavins, Jene Bennett, Samuel R. Mercer, Frank B. Ramsey, Editor of The Journal, Mrs. Jackie Stahl, Assistant Editor; Drs. Lall G. Montgomery and Alvin J. Haley. Drs. Cavins, Mercer and Montgomery are Associate Editors; the other physicians are members of the board.




**SCIENTIFIC EXHIBITS** are a point of interest at every convention. Dr. Edwin E. Pontius, Indianapolis pathologist, discusses his exhibit on "Cloacogenic Anorectal Carcinoma" with Dr. J. O. Ritchey, Professor Emeritus of the Indiana University School of Medicine.



**WOMEN PHYSICIANS** met this year for their annual dinner meeting at the Indianapolis Athletic Club.



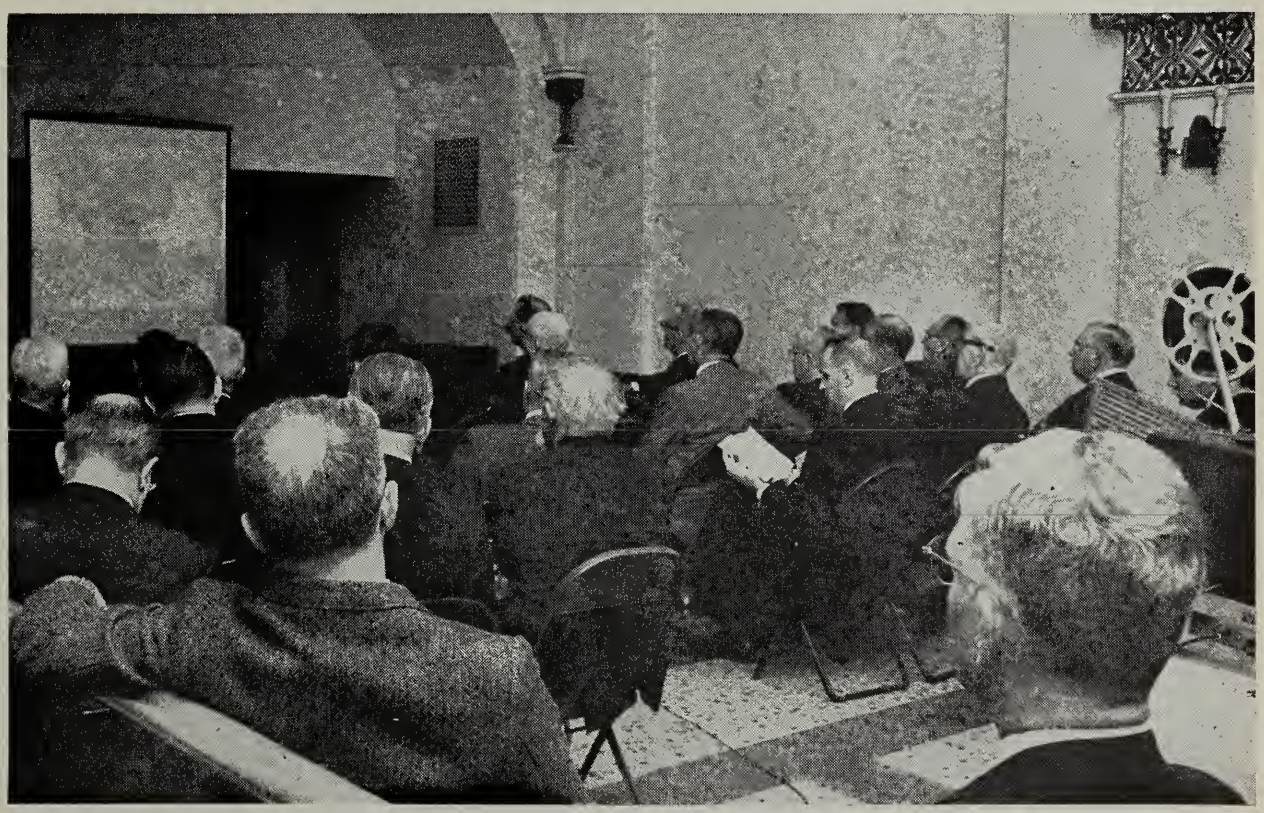
**THE ART AND HOBBY SHOW** is another convention highlight which evokes a lot of interest. Dr. Robert E. Arendell, of Evansville, discusses his coin collection with Dr. Charles Schneider, chairman of the show.



**FIRESIDE CONFERENCES** on Cardio-Respiratory diseases drew the usual crowds for the meeting Tuesday night. This is the fifth year these conferences have been such a successful part of the convention.



**VISITORS** from three continents attended the convention this year as guests of Dr. Lall G. Montgomery, Muncie. Anna Luisa Rodriguez, a fellow in anesthesiology at Mercy Hospital in Pittsburgh, is from Columbia, South America; Ellen Wellmann, originally from Germany, is a third year medical student and Dr. Luisa Latuaco, a fellow in pathology at Ball Memorial Hospital in Muncie, is from the Philippines.



**CONTINUOUS MOVIES** were shown this year and drew capacity crowds.




**AN INNOVATION** at the convention this year was a tour of the Indiana University Medical Center facilities Wednesday morning. Buses, provided by Eli Lilly & Company, picked up the doctors at the convention and returned them there after the tour.




**A SYMPOSIUM** on "The Role of the Family Physician in Workmen's Compensation" highlighted the Wednesday morning scientific meeting.



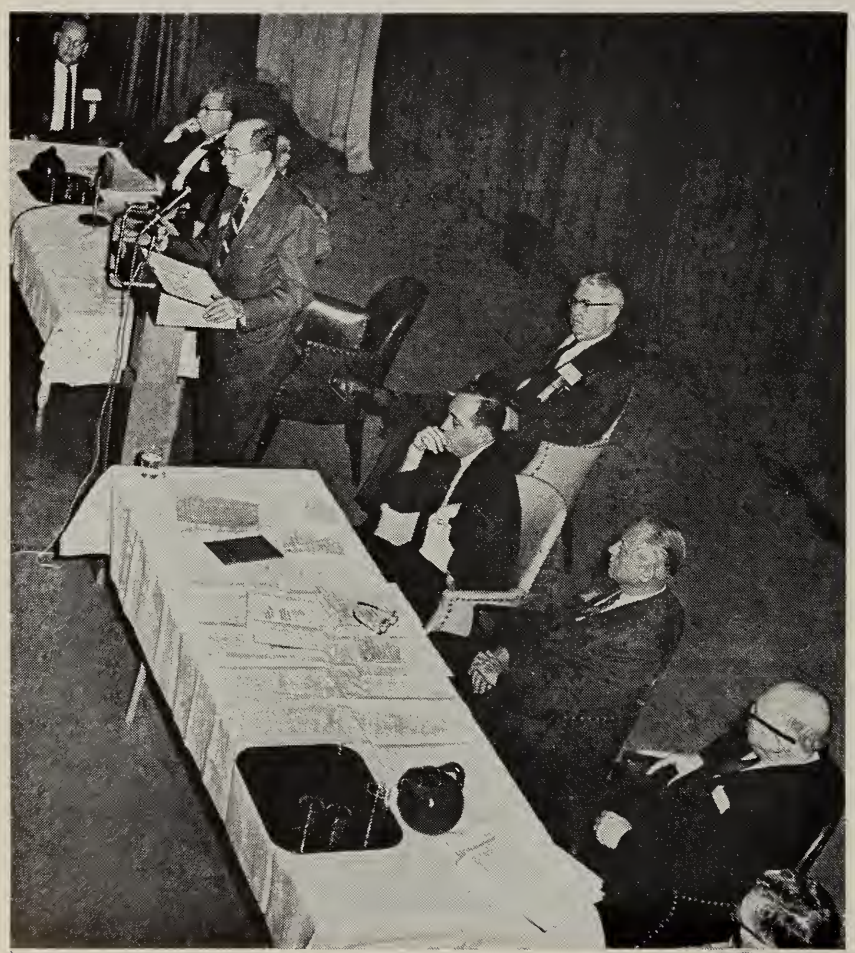

DR. WILLIAM C. SPENCER, director of the Texas Institute for Research and Rehabilitation at Houston, was given the annual physician's award from the President's Committee on Employment of the Handicapped at a special luncheon Wednesday. Harold Russell, chairman of the President's committee, made the presentation.




DR. HENRY F. HOWE, director of the AMA Council on Occupational Health, presented Harold Russell with a permanent bronze plaque which contains the names of all past winners of the physician's award and the signatures of the President in office at the time of the presentations. The plaque was a gift to the President's committee from the AMA.



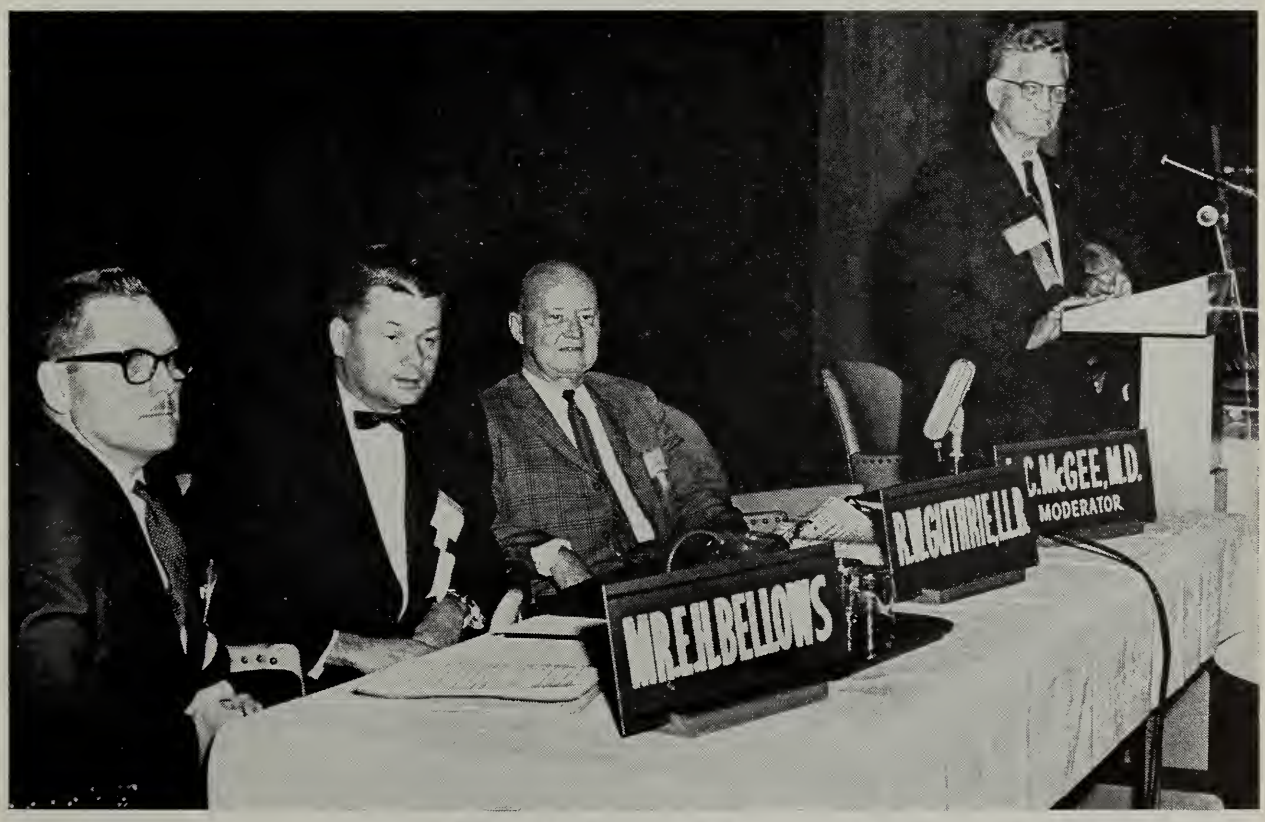
**A SPECIAL AWARD** from President Johnson was given to Dr. Edward Holmblad, Chicago, for his many years of service as head of the President's medical advisory committee.



**THE SPECIAL MEDICARE CONFERENCE** on Wednesday drew capacity crowds as physicians listened to a distinguished panel try to answer their many questions about the new law.




DR. HOWARD C. JACKSON, Madison, brought a group of Explorer Scouts to the convention this year. The Scouts visited the exhibits and "tried out" some of the physician's paraphernalia. The Scouts are (left to right) Edward Banks, Bob Canida, Allen Perry and Brian Cox.




"ROLE OF THE FAMILY PHYSICIAN IN EMPLOYEE HEALTH PROBLEMS" was the topic of the Wednesday afternoon joint scientific meeting.



ISMA president-elect, Dr. Kenneth O. Neumann, enjoyed the Gaslight Party activities Wednesday night with Dr. Eugene S. Rifner, Van Buren. They officially became president and president-elect of the association on Thursday.



THE GASLIGHT girls from New York and Chicago provided the evening's entertainment.



"TALKING" with a rather quiet Gaslight girl are Dr. and Mrs. William Kendrick, co-chairmen of the Gaslight Party.



MRS. H. CARTER DUNSTONE, president of the Woman's Auxiliary, chatted with members of the auxiliary who dropped by her table at the Gaslight Party Wednesday night.



YOU'D never believe it, but that's Dr. Dennis Megenhardt under that "fluff." He passed out candy canes to party-goers all evening and even to one of the Gaslight girls.



BAGPIPERS added a colorful note to the already colorful evening at the Athenaeum.



FIFTY-YEAR CLUB MEMBERS gathered for their traditional glass of champagne and reception before the President's luncheon on Thursday.



THE "HISTORY OF MEDICINE" exhibit from Parke, Davis & Company drew capacity crowds throughout the convention. Here Dr. and Mrs. John E. Schreimer, Bremen and Dr. and Mrs. Jesse Benz, Marengo, look at the excellent collection of paintings.




**DR. BETTY DUKES,** of Dugger, was named "Physician of the Year" by the Indiana Mental Health Association at the President's luncheon in the Murat Temple. Dr. Dukes received a plaque and $1,000 in recognition of the work she has done for the mentally ill and the retarded.




**MR. AND MRS. HERMAN KRANNERT** were given a beautiful plaque signifying their many contributions to medical education at the luncheon.




DR. ELVIS J. STAHR, president of Indiana University, was honored for his continuing interest in the development of medical education.




SCIENTIFIC EXHIBIT winner Dr. Arthur H. Griep, accepts his first place award from Dr. Richard B. Hovda, chairman of the exhibits.



WISH-TV was honored by the association for its public service program entitled "Ask Your Doctor." David L. Smith, program manager of the station, accepted the award from Dr. Black.



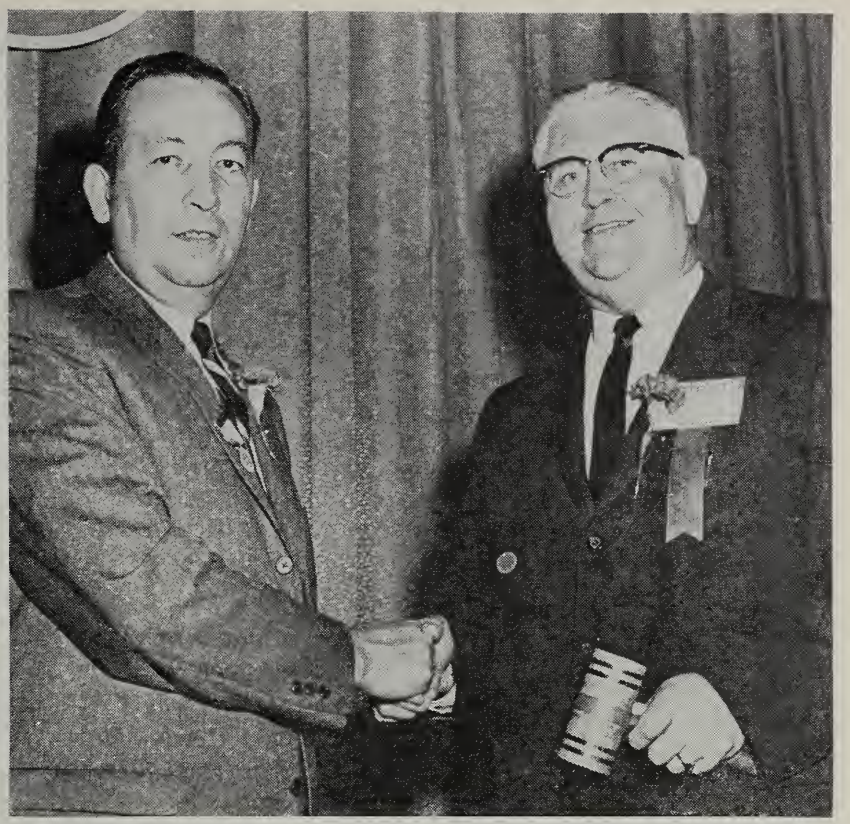
WFBM-TV was cited for its television show entitled "The Way of Sound," a documentary outlining the accomplishments and goals of the Speech and Hearing Clinic at the I. U. Medical Center. Program manager Jerry Chapman accepted the award.



HARRISON ULLMANN, writer for the Indianapolis Star, was honored for a series of 29 separate articles on a variety of subjects dealing with health problems of the public, research, medical economics, hospital care, etc.



MISS JOAN EVANS, Radio Station WIBC, was given an award for a program on her Indianapolis Today series dealing with "The Rising Rates of Venereal Disease and Illegitimacy among Teen-Agers."



**NEW LEADER**—Dr. Joe Black presents the presidential gavel to Dr. Kenneth O. Neumann.




**DR. KENNETH O. NEUMANN**, president for 1965-66, presents the plaque to Dr. Joe Black, out-going president.



DR. KENNETH O. NEUMANN congratulates Dr. E. S. Rifner on being chosen president-elect of ISMA.



THE PRESIDENT'S LUNCHEON—overall view of the capacity crowd which attended the annual event.



**THE "EV AND CHARLIE SHOW,"** featuring Hon. Charles Halleck, Congressman from Indiana, and Sen. Everett Dirksen, of Illinois, highlighted the President's Luncheon on Thursday.



**SPECIAL CEREMONIES** honoring former members of the AMA Council on Occupational Health was the highlight of the 25th Congress on Occupational Health Anniversary dinner at the Columbia Club Thursday night.

*Convention Election Results:*

# Dr. E. S. Rifner is Named President-Elect

Dr. Eugene S. Rifner, Van Buren general practitioner, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October.

Graduated from the Indiana University School of Medicine in 1945, Dr. Rifner is one of the youngest president-elects ever selected for the position. He served in World War II, was discharged in 1948 with the rank of captain, and went to Van Buren where he has been in general practice.

Dr. Rifner served on the ISMA Commission on Public Health, and for several years was chairman of the commission's subcommittee on Physician Placement and Rural Health, playing an instrumental role in conducting the Junior-Senior Day activities at Indiana University.

He has also served as Chairman of the Council; Councilor from the Eleventh District since 1960; on the Liaison Committee with Blue Cross; as president of the Indiana Academy of General Practice's Eleventh District and on the Blue Cross Board. Dr. Rifner is on the staff of Marion General Hospital and has served as Chief of Obstetrics at the hospital and also as secretary of the hospital staff.

Also taking office during the convention were Drs. Ottis N. Olvey, Indianapolis, re-elected treasurer; Lester H. Hoyt, Indianapolis, re-elected assistant treasurer and E. T. Edwards, Vincennes, elected chairman of the Council. Dr. Ralph V. Everly, Indianapolis, was re-elected chairman of the Executive Committee.

Re-elected delegates to the AMA for the two-year term ending December 31, 1968, were Drs. Guy A. Owsley, Hartford City and Jack E. Shields, Brownstown. Drs. Maurice E. Glock, Fort Wayne and Dwight W. Schuster, Indianapolis, were elected their alternates for the same term.

Councilors who will represent their respective districts until October, 1968 are Drs. P. J. V. Corcoran, Evansville, First District; Robert M. Reid, Columbus, Fourth District; Albert M. Donato, Indianapolis, Seventh District; and Otis R. Bowen, Bremen, Thirteenth District. (Dr. Lowell Hillis, Logansport, assumed the role of councilor from the Eleventh District when Dr. Rifner was elected president-elect. He will serve until 1966).

Alternate councilors who will represent their respective districts until 1968 are Drs. Philip T. Holland, Bloomington, Second District; Elmer L. Wallace, New Albany, Third District; Clarence G. Kern, Lebanon, Ninth District and William Clark, Fort Wayne, Twelfth District.

Results of the various section elections are as follows:

*Section on Surgery*: Chairman, Donald W. Meier, Bluffton; Vice-chairman, Joseph C. Finneran, Indianapolis; Secretary, Donald M. Schlegel, Indianapolis.

*Section on Internal Medicine*: Chairman, Charles M. Sinn, Evansville; Vice-chairman, Louis F. Sandock, South Bend; Secretary, Robert L. Rudesill, Indianapolis.

*Section on Ophthalmology and Otolaryngology*: Chairman, John M. Thompson, South Bend; Vice-chairman, Thomas W. Johnson, Indianapolis; Secretary, M. Richard Harding, Indianapolis.

*Section on Anesthesiology*: Chairman, Richard H. Stein, Vincennes; Vice-chairman, Eugene Schmidt, Fort Wayne; Secretary, William M. Matthews, Indianapolis.

*Section on General Practice*: Chairman, Forrest Babb, Stockwell; Vice-chairman, Ross L. Egger, Middletown; Secretary, Jay S. Reese, Martinsville.

*Section on Obstetrics and Gynecology*: Chairman, Frank C. Donaldson, Anderson; Vice-chairman, Joseph F. Thompson, Indianapolis; Secretary, Robert M. Reid, Columbus.

*Selection on Public Health and Preventive Medicine*: Chairman, Philip J. Rosenbloom, Gary; Vice-chairman, Donald M. Kerr, Bedford; Secretary, Henry G. Nester, Indianapolis.

*Section on Radiology*: Chairman, Louis C. Bixler, South Bend; Vice-chairman, William J. Stangle, Bloomington; Secretary, Richard A. Silver, Indianapolis.

*Section on Nervous and Mental Diseases*: Chairman, DeWitt W. Brown, Indianapolis; Vice-chairman, Lester D. Borough, South Bend; Secretary, Gene E. Lynn, Indianapolis.

*Section on Pathology*: Chairman, Charles E. Boonstra, Bluffton; Secretary, Robert L. Costin, Indianapolis.

# THE WINNERS—116th Annual Convention

# Indianapolis, Oct. 11-14, 1965

## *Art and Hobby Show*

*Class I — Oil Painting*

First: Charles P. Schneider, M.D., Evansville — "The General"

Second: J. W. Begley, M.D., Evansville — "Blue Pitcher"

Third: T. T. Suzuki, M.D., Covington — "Mecca Bridge"

*Class II — Black and White Photography*

First: Walter Dycus, M.D., Evansville — "Gold Mine in the Sky #1"

Second: Walter Dycus, M.D., Evansville — "Gold Mine in the Sky #2"

*Class III — Drawing*

First: W. L. Harlan, M.D., Evansville — "Michigan City Yacht Basin" (watercolor)

Second: W. L. Harlan, M.D., Evansville — "Maid Marian" (charcoal)

Third: W. L. Harlan, M.D., Evansville — "Michigan City Lighthouse" (watercolor)

*Class IV — Sculpture*

First: W. L. Harlan, M.D., Evansville — "Head of Carol Pavlick" (gilt wood carving)

*Class V — Crafts*

First: William Robertson, M.D., Spiceland — (occasional table)

Second: William Robertson, M.D., Spiceland — (coffee table)

Third: William Robertson, M.D., Spiceland — (occasional table)

*Class VI — Collection and Hobbies*

First: Robert Arendell, M.D., Evansville — (coin collection)

Second: Edward L. TerBush, M.D., Logansport — (comparative fee schedules — 1865 to 1965)

## *Scientific Exhibit Award Winners—1965*

First Place: Nocturnal Angina Pectoris — Significance?

Exhibitor: Arthur H. Griep, M.D., Evansville

Second Place: Cloacogenic Anorectal Carcinoma

Exhibitor: Edwin E. Pontius, M.D., Indianapolis

Third Place: Hiatal Hernia Complex

Exhibitor: J. K. Berman, M.D., Indianapolis

# President's Address

JOE M. BLACK, M.D.
Seymour

THIS was a year that was.

This was a year of pleasantries. Traveling 15,000 miles, attending sessions and conferences of the AMA, visiting your congressmen in our capitol, district meetings in various areas of Indiana, Council meetings in our excellent headquarters, annual meetings of the ancillary health groups, representing the ISMA at our neighboring state medical societies and representing the Indiana State Medical Association before many organizations. The meetings were educational, the fellowship excellent and the hospitality gracious.

This was a year of despair.

Medicare became Public Law 89-97. This law was strenuously opposed by your society, however one wonders if we didn't learn a lesson in public relations, public information and legislative persuasion. Perhaps a definite offense, a sturdier and more strenuous defense should be formulated. It has been said we lost a battle and not the war, suffered a Dunkirk, not a Waterloo. Socialization of our profession is on the horizon. This is a warning to regroup our forces, re-affirm our position and prepare for our future, as all has not been lost.

Much has been written, many have debated and more has been spoken about participation versus non-participation. Philosophically, American physicians respect non-participation but physicians are professional members of a time-honored and respected profession, hence the practical decision will be each individual's responsibililty.

Should we have a association — or a union?

This was a year of observation. I would like to briefly mention three specific areas for your information that need some deliberation and action.

1. Attention by everyone to the problems of federal and state legislation, their impact and encroachment on the patient-physician relationships.
2. To the problems of communication for our physicians to understand and foresee possible pitfalls and problems. It has been difficult even with the outstanding performance of the Indiana State Medical Association executive staff to inform the physicians of their actions and program.
3. It might be considered communications, but I feel it falls in the avenue of cooperation of the profession with the various ancillary health organizations involved and interested in specific areas of health care.

We sometimes neglect to take the time to be important spokes in the wheel of an organization which is trying to promote better health for our citizens. We further need to cooperate with other organizations who are interested in our great state and our great country, trying to understand their problems and trying to promote a better understanding of ours.

Thanks for the opportunity of serving you and working with you. ◄



# Minutes of the House of Delegates

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# House of Delegates Proceedings

## INDIANAPOLIS SESSION

## October 11-14, 1965

The House of Delegates convened at 7:00 p.m., Monday, October 11, 1965, in the Ballroom of the Columbia Club, and again at 2:00 p.m., Thursday, October 14, 1965, in the Little Auditorium of the Athenaeum, Indianapolis. Dr. Kenneth O. Neumann, president-elect, called the first meeting to order and presided until Dr. Joseph M. Black, the president, delivered his presidential address. Dr. Black and Dr. Neumann presided at the final meeting of the House on October 14.

### Credentials Committee Reports

On motion of many, duly seconded, attendance slips signed by the delegates were accepted in lieu of a roll call at the first meeting. Dr. Dean K. Stinson, chairman of the Credentials Committee, reported 108 delegates, six past presidents, nine councilors, three alternate councilors, the president, the president-elect, the assistant treasurer, two delegates to the AMA, the editor of *The Journal* and 18 guests present at this meeting.

At the second meeting it was moved by many, motion duly seconded, put to vote, and carried, that attendance slips filled in by the delegates would constitute the roll call. Present for the second meeting, as recorded on signed attendance slips, were 108 delegates, four past presidents, ten councilors, two alternate councilors, the president, the president-elect, the treasurer, the assistant treasurer, three delegates to the AMA, the editor of *The Journal* and six guests.

According to Chapter IV, Section 3, of the By-laws, 50 delegates constitute a quorum. The House of Delegates, therefore, was declared open and ready for the transaction of business.

The chairman announced that a resumé of the panel discussion on the Medicare program, presented at the special meeting of the AMA House of Delegates in Chicago on October 1 and 2, would be presented following adjournment of the first meeting of the House of Delegates and therefore an attempt would be made to conduct the formal business of the House as expeditiously as possible in order to provide time for this discussion. This resumé is to be filed as official business of the House of Delegates.

### In Memoriam

The House rose for a moment in tribute and memory of the following physicians who had served as members of the House of Delegates, or in an official capacity in the association and who had passed away since the 1964 convention:

**DANIEL S. ADAMS**, Fort Myers, Florida (formerly Indianapolis). Chairman, 1927, and vice-chairman, 1930, Section on Ophthalmology and Otolaryngology.

**ORRIS T. ALLEN**, Terre Haute. Member, Committee on Conservation of Vision, 1939-1946 (chairman, 1941); member, Committee on Hard of Hearing, 1943-47.

**PHILIP H. BECKER**, Crown Point. Member, Anti-Tuberculosis Committee, 1942-47 (chairman, 1945); member, Committee on Tuberculosis, 1948-49, 1953-54.

**ERWIN BLACKBURN**, Westville. Delegate, St. Joseph County, 1937-42, 1947-49; member, Committee on Military Manpower, 1953-57; member, Committee on Public Relations, 1954.

**PAUL J. BLESSINGER**, Jasper. Secretary, Dubois County Medical Society, 1941-46; delegate, Dubois County, 1942-44.

**HARRY F. CARPENTIER**, Princeton. Secretary, 1947 and 1959, and president, 1958, Gibson County Medical Society.

**GEORGE R. DANIELS**, Marion. Secretary, Grant County Medical Society, 1913; member, Committee on Administration and Medical Defense, 1919-1926; member, Committee on Public Policy and Legislation, 1923-24, 1933-52 (chairman, 1933); chairman, Committee on Arrangements, 1925; member, Committee on Budget, 1927-29; president, Indiana State Medical Association, 1928; member, Executive Committee, 1928; member, Committee on Physician-Patient Relations, 1950.

**EDGAR C. DAVIS**, Muncie. Member, Committee on Civic and Industrial Relations, 1943; vice-chairman, Section on Ophthalmology and Otolaryngology, 1945-46.

**CARLTON N. FISCHER**, LaPorte. Secretary, LaPorte County Medical Society, 1950.

**HOMER E. GLOCK**, Fort Wayne. Member, Committee on Scientific Exhibit, 1916.

**NOVY E. GOBBEL**, English. Member, Committee on Convention Arrangements, 1945; delegate, Crawford County, 1956, 1958, 1963.

**AUGUSTUS P. HAUSS**, New Albany. Member, Committee on Physical Therapy, 1941-43; member, the Council, 1943 to Dec. 17, 1947; member, Committee on Public Policy and Legislation, 1943; member, Permanent Study Committee on Health Insurance, 1944; member, Committee on Industrial Health, 1944; member, Committee for the Study of Lay Activity in Medical Practice, 1944; co-chairman, Committee on Convention Arrangements, 1945-47; member, Committee on Prepayment of Medical and Surgical Service, 1945; member, Committee on Indiana Inter-Professional Health Council, 1946-49; member, Executive Committee, 1948-49; president, Indiana State Medical Association, 1949; member, Committee on Centennial Celebration and History, 1949; ex-officio member, Committee on Medical and Nursing School Scholarships, 1949; chairman, Committee on Prepaid Medical and Hospital Insurance, 1950-51; member, Committee on Physician-Patient Relations, 1950, 1952-57 (chairman, 1952-54).

**SAMUEL W. HOOKE**, Noblesville. Secretary, Hamilton County Medical Society, 1916; delegate, Hamilton County, 1934.

**WAYNE W. HOUSER**, Monon. President, White County Medical Society, 1963, and secretary, 1965.

**ALFRED S. JAEGER**, Indianapolis. Member, Committee on Prevention of Venereal Disease, 1910-11; member, Committee on Compulsory Ventilation, 1910-11; chairman, Surgical Section, 1922; member, Committee on Postgraduate Study, 1927-29.

**DONALD D. JOHNSTON**, Thousand Oaks, California (formerly Fort Wayne and Westville). Secretary, Allen County Medical Society, 1923-26.

**COLONEL G. MACKEY**, Logansport. Secretary, Marshall County Medical Society, 1922.

**FLOYD B. MITMAN**, Huntington. Secretary, Huntington County Medical Society, 1928-29; member, Committee on Public Relations, 1953.

**ALLEN A. NORRIS**, Elkhart. Secretary, Elkhart County Medical Society, 1909, 1910.

**FRED McKAY RUBY**, Milwaukee (formerly Union City). Member, Committee on Conservation of Vision and Hearing, 1916; vice-chairman, 1925, and chairman, 1937, Section on Ophthalmology and Otolaryngology; delegate, Randolph County, 1937.

**CYRUS W. RUTHERFORD**, Indianapolis. Member, 1945-48, and chairman, 1946 and 1949, Committee on Conservation of Vision; member, Committee on Civic Relationship and Community Health Agencies, 1949.

**KEITH SELBY**, South Bend. President, St. Joseph County Medical Society, 1957; member, Medical-Legal Committee, 1959-61.

**FREDERICK R. SMITH**, Spencer. Delegate, Owen-Monroe County Medical Society, 1949, 1962-64; member, Commission on Governmental Medical Services, 1958-59.

**E. BRAYTON SMOOT**, Washington. Secretary, Daviess-Martin County Medical Society, 1931-34.

**HARRISON S. THURSTON**, North Webster (formerly Indianapolis). Member, Committee on Scientific Exhibit, 1916.

**FRANK A. VanSANDT**, Bloomfield. Secretary, Greene County Medical Society, 1908, 1919; member, Committee on Venereal Diseases, 1911-12.

**GROVER L. VERPLANK**, Gary. Delegate, Lake County, 1934, 1944, 1946-47; chairman, Advisory Committee to the Bureau of Maternal and Child Health of the Indiana State Board of Health, 1945.

**ROBERT L. WITHAM**, Indianapolis. President, Marshall County Medical Society, 1954.

**JAMES R. WOODS**, Greenfield. Secretary, Hancock County Medical Society, 1939-40, 1942, 1950.

## 1964 Minutes

**On motion of Dr. P. J. Rosenbloom, seconded by many, minutes of the meetings held at Indianapolis on October 13 and 15, 1964, were approved as printed in the December, 1964, *Journal*.**

## Introduction of Guests

MR. MICHAEL SILBERT, president, Indiana Chapter of Student AMA.

GEORGE W. PEDIGO, Jr., Louisville, president-elect, Kentucky Medical Association.

The president read Chapter XXXII, Section 1, of the Bylaws, and Article XIV of the Constitution regarding amendments to the Bylaws and the Constitution.

## 1965 Reference Committees

The chairman announced the appointment of reference committees for the 1965 session as follows:

**Sections and Section Work:**
A. E. Stouder, Kempton (Tipton), *Chairman*
Sprague H. Gardiner, Indianapolis (Marion)
Forrest J. Babb, Stockwell (Tippecanoe)
William D. Scharbrough, Ewing (Jackson-Jennings)
Charles M. Sinn, Evansville (Vanderburgh)

**Rules and Order of Business:**
Lowell W. Painter, Winchester (Randolph), *Chairman*
Earl W. Bailey, Logansport (Cass)
William Shaffer, Greensburg (Decatur)
John O. Butler, Indianapolis (Marion)
Donald R. LaFollette, New Albany (Floyd)

**Medical Education and Hospitals:**
John W. Beeler, Indianapolis (Marion), *Chairman*
William R. Clark, Fort Wayne (Allen)
Thomas C. Moore, Muncie (Delaware-Blackford)
Glenn W. Irwin, Jr., Indianapolis (Marion)
John D. Wilson, Evansville (Vanderburgh)

**Legislation:**
James H. Gosman, Indianapolis (Marion), *Chairman*
Lee Trachtenberg, Munster (Lake)
Thomas M. Brown, Muncie (Delaware-Blackford)
James M. Kirtley, Crawfordsville (Montgomery)
Clarence G. Kern, Lebanon (Boone)

**Public Relations:**
Frank H. Green, Rushville (Rush), *Chairman*
Eugene F. Senseny, Fort Wayne (Allen)
George T. Lukemeyer, Indianapolis (Marion)
George W. Willison, Evansville (Vanderburgh)
William F. Kerrigan, Connersville (Fayette-Franklin)

**Hygiene and Public Health:**
Robert M. Seibel, Nashville (Bartholomew-Brown), *Chairman*
Gilbert M. Wilhelmus, Evansville (Vanderburgh)
W. A. Nelson, Gary (Lake)
Wilson L. Dalton, Shelbyville (Shelby)
Joseph C. Finneran, Indianapolis (Marion)

**Amendments to Constitution and Bylaws:**
Gordon S. Fessler, Rising Sun (Dearborn-Ohio), *Chairman*
Paul W. Sparks, Winchester (Randolph)
Thomas D. Armstrong, Michigan City (LaPorte)
Floyd A. Boyer, Indianapolis (Marion)
Joe E. Dukes, Dugger (Sullivan)

**Reports of Officers:**
Leslie M. Baker, Aurora (Dearborn-Ohio), *Chairman*
P. J. Rosenbloom, Gary (Lake)
Charles A. Jones, Franklin (Johnson)
Michael W. Manzie, Indianapolis (Marion)
Thomas G. Hamilton, Columbia City (Whitley)

**Credentials:**
Dean K. Stinson, Rochester (Fulton), *Chairman*
John F. Phillips, Bluffton (Wells)
Robert M. Brown, Marion (Grant)
David Hadley, Indianapolis (Marion)
Bill E. Freeland, Batesville (Ripley)

**Insurance:**
Malcolm O. Scamahorn, Pittsboro (Hendricks), *Chairman*
Elmer L. Wallace, New Albany (Floyd)
W. R. Van Den Bosch, Lafayette (Tippecanoe)
M. B. Gevirtz, Munster (Lake)
Harry R. Baxter, Seymour (Jackson-Jennings)

**Miscellaneous Business:**

Dwight W. Schuster, Indianapolis (Marion), *Chairman*
Lowell J. Hillis, Logansport (Cass)
Glen Ward Lee, Richmond (Wayne-Union)
Thomas J. Conway, Terre Haute (Vigo)
Loren H. Martin, Indianapolis (Marion)

# Reports of Reference Committees

## REPORTS OF OFFICERS

The following matters were referred to the Reference Committee on Reports of Officers. All reports will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association*, with the exceptions herein listed. The president's address will be found on page 1404, of the December, 1965, *Journal*. The addresses of the president-elect, the president of the Woman's Auxiliary, the supplemental report of the Eleventh Medical District and the report of the president of the Indiana Student AMA are printed herewith.

President's address
President-elect's address
Executive Secretary (page 997)
Treasurer (pages 997-1000)
Chairman of Council (pages 1000-1004)
Councilors' reports (pages 1004-1007) and supplemental report of Eleventh Councilor District
Executive Committee (pages 1011-1013)
Address of President of Woman's Auxiliary
*Journal* Editor (page 1007)
Delegates to AMA (pages 1007-1010)
Address of President of Indiana Student AMA

### President's Address

The address of the president, Dr. Joseph M. Black, is printed on page 1404, of the December, 1965, *Journal of the Indiana State Medical Association.*

### *REFERENCE COMMITTEE ACTION*

Dr. Leslie M. Baker, chairman, presented the following report:

The presidential address was reviewed and approved. We congratulate him on his record and expression of the sounding of the call to drop the complacency of medical men everywhere and, instead of waiting for a magic formula, to start from the grass roots. We reaffirm our position and regroup in back of our officers, knowing that the responsibility is for all of us and not just the elected few.

Mr. Chairman, I move the adoption of this portion of the report.

**(Motion seconded, put to vote, and carried.)**

### President-Elect's Address

DR. KENNETH O. NEUMANN, president-elect, addressed the House as follows:

As your president-elect, I have enjoyed the past year; but the pleasure has been tempered by the many problems forced upon us.

I have enjoyed meeting with many of your societies and would have liked to visit more except for the many other meetings that I, as well as the other officers, have found it necessary to attend. To give you some idea of the meetings and time involved, in the past 360 days I have been out of town on 104 days for at least one-half day —62 of these were entire days devoted to ISMA business. At many times, Dr. Black, Dr. Rifner, and I have simultaneously attended separate meetings in different areas of the state.

With the passage of Public Law 89-97, a new era of hospital-medical care arrived. This is *not* a new era of which we can talk in glowing terms. Rather, I think, it will be an era of Regret, Regression, Regimentation. In spite of the vigorous opposition of American medicine to this program, *and* the offering of alternative programs by us, Congress chose not to take our advice and quickly passed the law.

Let me recall for you some of our basic objections:

1. Free care should *not* be provided for all, but total care should be provided for those in need. We felt many older citizens are well able to care for themselves.
2. The program should NOT be financed through the Social Security system.
3. The tax burden on the young people would be staggering, and those with a low income would be paying a larger proportion of the cost than those with a higher income.
4. Hospital facilities would be taxed beyond capacity.
5. Administrative costs would be huge.
6. There would be a disruption of physician-patient-hospital relations.

While the legislation was being considered, it was our contention that it was poorly planned and needed further study. I see no reason to change our opinion. Our views were ignored.

In the coming year, and in the years to come, each of us will need to do a painful job of SOUL-SEARCHING as to what our attitude will be. How *far* can we be pushed? How *much* can we compromise? What *must we do* if our patients cannot obtain the care *we* think they should have?

What we have fought for has crumbled! Now we must regroup our forces—and by this I mean *all* the facets of medicine—and try to work things out together. We cannot go off into little groups. We *are* physicians and we *are* citizens. We *will* continue to care for our patients, we *will* continue to point out defects and weaknesses in these laws and in others to come. We *will* attempt to correct these defects. We will try to maintain our self-respect, but we *cannot* put our heads in the sand, or place our necks in the noose.

Our opposition will be *ruthless*. We must anticipate that every attempt will be made to place the blame for all the flaws in these laws on the physician. In the common vernacular—"they will try to

place the cat on our back."

You can expect to be blamed —

Because the patient cannot get into the hospital,

Because the patient is kept in the hospital too long,

Because the patient is discharged too soon,

Because service is hard to obtain,

Because costs are rising rapidly,

Because taxes will have to be increased.

Let us remember, and let us point out to them again and again, that we *repeatedly warned* of these problems and our advice was ignored.

We are faced with many *other* problems:

1. Reimbursement under Medicare; relations with hospital specialists; utilization; fiscal intermediaries; all pose grave problems.

2. How do we effectively cope with plans for further socialization—What about Legal-care, Denta-Care, Auto-Care, and other care progress. Where do *we* draw the line? How *do we* help draw the line?

3. Hospital-physician relations will be a difficult area in the future. Yet we each have the same objective—better patient care at less cost. It seems to me that *we* must resolve these problems, or someone else will, and perhaps neither of our groups will like it.

4. We need to work closer with other professional groups with similar interests.

5. Each of us should increase our participation in civic, POLITICAL and association activities.

6. How can we get more capable and qualified young people interested in health careers?

7. We need to provide faster, more meaningful communication between our members, specialty groups and other health organizations.

8. Improved facilities for our medical school. I. U. has done a magnificent job with limited facilities. These need to be expanded. DO we need more facilities?

9. Increased facilities for postgraduate medical training, internships, residencies, as well as for practicing physicians.

10. Improvement in traffic safety. ISMA has long been a leader in the field, but we can do more.

AS ALWAYS—we are ready to sit down with any groups interested in these problems and earnestly try to arrive at a mutually agreeable solution. We have taken the initiative in many of these areas, and we need to expand our efforts. It will take your utmost help and understanding. I am sorry that I don't have the answers for you. I have some strong personal opinions; but I have no intention of trying to force these upon you as has been done in some other organizations. I believe there are certain basic principles relating to Medicine and medical care where we *should* have drawn a line. At one time we held certain basic principles to which we adhered. In the past few years we have negotiated, collaborated, compromised and retreated to the position we have now reached. It is apparent *now* that our actions have been taken for weakness, indecision, lethargy or even willing compliance.

When we ask, why cannot *others* see where government control will lead; should we not ask *ourselves* the same question? Has not negotiation, collaboration, compromise and retreat destroyed the free practice of medicine in England, Italy, Belgium and more recently in Canada? Has not a similar path destroyed the very political freedom of many countries? Will it not do the same for us?

Should we not *now* draw a line, a set of principles, a guide, if you will for physician, patient, hospital and third-party relations. Then let others know clearly and precisely where we stand.

This House of Delegates, the Council and the Executive Committee, and *you*, working through these spokesmen, will determine our POLICY and I shall do my best to act in accord with your expressed wishes.

I think that the words Winston Churchill uttered after Munich apply to us today—

> "And do not suppose that this is the end! This is only the beginning of reckoning! This is only the *first* sip—the *first* foretaste of a bitter cup which will be offered to us year by year—unless we take our stand for freedom as in the olden time."

I hope the stand *we* take for medicine and for *our patients* is RIGHT. Thank you.

## *REFERENCE COMMITTEE ACTION*

Dr. Leslie M. Baker, chairman, continued with the report of the Reference Committee on Reports of Officers, which was adopted section by section, as read, as follows:

The report of Doctor Neumann, president-elect, was then reviewed and the following we point out to the membership as important for this momentous coming year. He exhorted us to regroup, reform and prepare for the second round, not to put our heads in the sand. He pointed out that we are physicians but we are citizens and this is, after all, the law of the land. He has capsulated our grievances and pointed out our objectives and we must follow along. We are fortunate to have such strong leadership at this most trying time.

### Report of Executive Secretary

The report of the executive secretary was then discussed and we congratulate him on another fine job. He has done his usual efficient effort. With the new programs we are offering, it seems that an increase in staff will be a necessity in the near future and the membership at large is to be so informed.

### Report of Treasurer

The treasurer's report was reviewed and we note that our investment structure is sound; our building program good; our *Journal* is in the black; we have some surpluses. The future may require more ammunition, as our responsibilities increase and our enemies are ever at hand. We wish to alert the organization that our needs to improve our

organization throughout the state might necessitate increasing demands on our already overburdened operating budget.

## Report of Chairman of Council

The report of the Council chairman was reviewed and we congratulate Eugene S. Rifner, M.D., on a difficult job exceptionally well handled.

## Supplemental Report of Eleventh Medical District

The Eleventh Medical District met in Peru, September 15, 1965. The Peru County Medical Society was the host of the district. The excellent program concerning "Fluid Balance" was given by Dr. William Segar of Indiana University and an excellent address given by Dr. Nicholas Nyaradi which stimulated all of us.

During the business meeting, Dr. Donald Ferrara of Peru was elected president of the district; Dr. Lowell J. Hillis of Logansport was re-elected alternate councilor; Dr. John A. Bowers of Kokomo was re-elected Blue Shield Board member; Dr. Max Earl was re-elected secretary-treasurer; and Dr. Christos D. Gatzimos of Logansport was elected necrologist.

The councilor gave the following report: Most of the work since we last met has been concerned with the recent changes in the law. There is no need to report these shortcomings. The Executive Committee of the Indiana State Medical Association has authorized the legal councilors to defend the principle of separate billing within our district. Judge Hamill has already begun this action. Areawide planning has come under the close scrutiny of the Council this past year. Much time has been spent by your councilor, as chairman of the Council, in traveling to two AMA conventions and one called meeting of the House of Delegates. The Council will have its second called meeting (called meetings are over and above the number prescribed by the Constitution) Sunday in preparation of policy of the ISMA delegates at the special meeting of the House of Delegates of the AMA early next month.

Since we last met, Medicare, which we fought so earnestly, has come into law. Now we are engaged in the evolution of ideas, change, conflicting thoughts and emotions which must of necessity follow the birth of such a new species.

We, your officers, are caught in the conflicting trains of ideas. Turncoats and collaborators rear their heads among us continually until it is difficult to discern at times who is honest and upright in his opinion and who is giving thought only for his own financial improvement and/or status which he feels will come from collaboration.

Amidst all this and all the new thinking which is so foreign to so many, we must quietly and with deep meditation study the new, and we must always remember these words of Lincoln:

"The dogmas of the quiet past are inadequate to the stormy present. The occasion is piled high with difficulty and we must rise with the occasion. As our case in new, so we must think anew and act anew. We must disenthrall ourselves and then we shall save our country."

I would advocate slowness of decision, but not to the point of stagnation, quiet meditation, but not complete silence and then decisive action. None of our deliberations will be worth the time spent if they are performed in the heat of anger or loss or humiliation or harassment. We must think anew and act anew. This does not mean, nor is it intended to mean, that we should be cooperative in the sense that the Trailmaster from the plains of Texas would have us. We are not his doggies to be herded at his will down that gully he calls the "Great Society."

From the position of defeat, it is difficult to look in any direction and find one small item of hope or molecule of optimism. But, if we build a fence about ourselves, soon we will find ourselves entrapped within that confine. But, we should look anew at our position and save all we can. Then look forward to improvements we can influence to the betterment of mankind, our patients, our country and ourselves.

Let us remember that under Medicare it is the patient who is indigent. The payer is wealthy and can afford all types and kinds of give-away programs—even more than you and I can imagine. Therefore, there is no reason for such a paternal master to enjoy the altruism so traditional of medicine. As stated in the Indiana resolution at the last AMA convention, he, the government, should be charged the usual and customary fee. At the present, the law would allow the physician to continue to bill the recipient of his services and thus cause the recipient to collect from said recipient benefactor. This has been the policy of organized medicine in Indiana when dealing with third parties. I trust that it shall remain so. It is necessary that it remain so for us to maintain any semblance of free enterprise.

I urge each of you to attend the ISMA convention as often, as long and as much as you possibly can. Please make it a point to attend reference committee meetings and state your views there. You are welcomed and urged to attend each House of Delegates meeting. Between now and then, I hope that each delegate would make resolutions known to his county society and would ask opinions of the members. Only in this way can he honestly represent the opinions of his county.

As I have stated many times before, it has been a pleasure and an honor to have served as councilor of the Eleventh Medical District this past year. I remain your humble servant. Thank you.

EUGENE S. RIFNER, M.D., *Councilor*

## *REFERENCE COMMITTEE ACTION*

Dr. Leslie M. Baker, chairman, continued with the report of the Reference Committee on Reports of Officers, which was adopted section by section, as read:

## Reports of Councilors

The reports of the councilors were reviewed and we noted no report from one Council member. Their duty, to receive information and participate in policy-making as Council members, makes necessary the dissemination of this knowledge to their component societies; only in this way does our organization become a truly democratic organization.

## Report of Editor of The Journal

The report of the editor of *The Journal* was reviewed and we note with pride our improved financial position. We exhort the membership at large to read our *Journal*, to peruse the advertisements and study the excellent scientific papers and the reports of your officers' and association activities.

## Report of Delegates to AMA

The reports of the AMA delegates were reviewed and we thank them for their efforts in our behalf. We commend them for an outstanding job in this difficult time.

## Woman's Auxiliary Presidential Address

MRS. H. CARTER DUNSTONE, Fort Wayne, president of the Woman's Auxiliary to the Indiana State Medical Association, addressed the House as follows:

As an auxiliary to the Indiana State Medical Association, we are proud of our organization. In our 37th year, with a total membership of 2,815, we are pleased to report our progress. We appreciate the guidance of our advisor, Dr. Everly, and the advisory board. The ISMA staff and Mr. Waggener have been most patient and helpful.

Our "Hoosier Doctor's Wife" has been published four times in its regular form plus one special legislative issue underwritten by the ISMA. Our editor, Jean Green, was signally honored by an appointment as contributing editor on the staff of the new national publication—"MD's Wife."

In legislation, 14 representative members from throughout the state worked with the state chairman to produce a "finger system" in getting information to the counties. Our members took courses, were notarized and searched out absentee ballots to process. Organized medicine still has its finger in the dike attempting to hold back the flood of government-controlled medicine. Realizing this, we are dedicated to assist in supporting the best medicine possible. Aware we cannot associate ourselves solely with medical legislation, we are determined to strive for the best legislation possible in all fields. To accomplish this, we are promoting political action courses and a membership well informed on all legislative matters.

For AMA-ERF we donated $11,983.12 to be utilized for medical schools and an additional $2,673.85 for loan fund—a total of $14,656.97. This earned us recognition from national. With the AMA supporting the new Institute of Biomedical Research, we are proud of the addition but our support will continue in the same two fields.

Our health careers activities and assistance were well accepted throughout the state with a reported loan fund of $12,470. Our prime objective is one of recruiting adequate numbers of young men and women into the varied and numerous health career courses essential to the practice of modern medicine. Source material has been available to schools through local auxiliaries working with guidance counselors and assisting with Health Career Days and clubs.

International health activities were given national recognition and our state chairman, Mrs. Matthews, was rewarded personally by appointment as a regional director. Time and space do not permit an itemized list of materials collected and shipped.

Mental health activities have encouraged the showing of films and participated in raising funds and providing gifts for mental institutions. They have been alert to the tax structure and have supported legislation to see that the salary level of professional personnel in our state institutions is of such a level that the Indiana salary schedule can compete with surrounding states.

In our community services projects—Rural Health has urged cooperation with farm safety, encouraged immunization and working on local levels with health agencies. Safety has assisted with supplying material on poison control, urged the use of seat belts and traffic control, which includes pedestrian and bicycle. Groups have worked on a program of GEMS or Good Emergency Mother Substitutes (a baby-sitting course). Disaster Preparedness has come into prominence with flood disasters and hurricanes causing emergencies on our homefront. Medical Self-Help courses were sponsored, care of the sick and injured classes were given and "mock disaster" participation carried out. Many communities participated in mass innoculation against polio with oral Sabin vaccine.

Our Area Workshops, held in September, were not as well attended as usual but enthusiasm of those present balanced the smaller number in the southern area. We have three vice-presidents representative of the southern, central and northern area and they chair the workshops.

Our national president of the woman's auxiliary urges that each county must basically determine for itself, with its medical advisory board, the areas of greatest concern in its community's health picture. This we attempt to do well.

## *REFERENCE COMMITTEE ACTION*

Dr. Leslie M. Baker, chairman, continued with the report of the Reference Committee on Reports of Officers, each section of which was adopted:

The report of the Woman's Auxiliary was reviewed and distaff members are to be commended. They are not only our helpmates, they also do a great deal of the activities for which we of the ISMA get credit. Their gracious financial contribution to AMA-ERF is gratefully acknowledged.

We urge the members to influence their wives to participate in the auxiliary activities.

## Executive Committee Report

The Executive Committee report, as printed in the Handbook, and the detailed minutes of the August meeting were reviewed. These committee members are to be commended for their dedicated and industrious discharge of their responsibilities. The volume of work represented by their report is tremendous and it would be enlightening for every member to be acquainted with their efforts.

## Report of Indiana Student AMA

MICHAEL Z. SILBERT, president of the Indiana Student AMA, reported as follows:

On behalf of the Student American Medical Association at Indiana University, I would like to express our gratitude for being allowed to report our activities to the House of Delegates of the Indiana State Medical Association.

Our organization is a service organization for the student. It serves him in many ways. We work to provide such tangible services as social, economic, extra-curricular academic and informative activities. In addition we work to provide such intangible services as providing training to accept our responsibilities as members of the medical profession and as leaders of society. We try to acquaint the student with the machinery and mechanics of organized medicine which have provided the best medical care in the world. We act as an autonomous organization both nationally and locally. The freedom to accept and to carry out responsibilities has been and will continue to be one of the most important factors contributing to our extra-curricular training for the future.

The specific services we provide include:

(1) Recruiting services, in conjunction with the Dean's office, in which students visit high schools throughout the state to provide information about medicine as a career. The students are familiar with current requirements and costs, and being close to the age of the high school student, are able to answer the questions they frequently ask.

(2) We act as a liaison between the student body and faculty. Our officers have regular meetings with the Dean and, in addition, through our campus newsletter, we are able to express student opinion to the faculty and likewise faculty opinion to the students.

We elect best pre-clinical and best clinical professors each year to show our appreciation for outstanding teaching efforts.

(3) We provide extra-curricular academic activities such as scientific competitions, noon movies and speakers.

(4) We provide economic services with a $50, thirty-day interest free loan, used book store and lab coats at a discount.

(5) Our national organization provides experience on regional and national levels as well as representing the interests of the medical student through our liaison committees with the AMA, AAMC and AHA. Our national organization provides insurance programs, the only journal for medical students and a national preceptor program.

(6) On the local level we provide similar activities. We are working with the Indiana Academy of General Practice and their GP Club, which I feel has had excellent reception among the students. Members of our council sat as ex-officio members on the ISMA standing commissions and thereby have been informed of the activities of organized medicine. This has been particularly stimulating to all the participating students. I sat on the Commission of Medical Education and Licensure where I saw the beginning of the preceptor program. I would like to say at this time there is tremendous student interest in this program.

(7) Last but not least we try to keep the student informed of changing trends in medicine by providing speakers and reprints of informative articles.

This has been the most difficult service to provide. We have found that the greatest stimulation to learn about these trends occurs when the student is able to see policies being made to meet or determine the trends.

We are very interested in increasing the liaison with ISMA and will appreciate all efforts to include us in as many local and state association activities as possible. SAMA chapters in Texas and California have close liaison with their local and state medical associations, which is apparently to their mutual benefit.

In closing I would like to repeat the words of our past president, Frank Johnson, in his speech to this meeting last year: "Our activities provide the learning experiences for the student which we hope will equip him to inherit and safeguard your and our most sacred possession—the practice of medicine." Again I thank you for this opportunity to speak. We of SAMA express best wishes for a successful convention.

## *REFERENCE COMMITTEE ACTION*

Dr. Leslie M. Baker, chairman, presented the following report, which was adopted:

The report of the student AMA was reviewed and we are fortunate in our state to have such an active chapter and we congratulate Mr. Michael Silbert on his outstanding work and excellent presentation.

**Dr. Baker's motion for adoption of the report of the Reference Committee on Reports of Officers as a whole was seconded, put to vote, and carried.**

## SECTIONS AND SECTION WORK

—No report

## RULES AND ORDER OF BUSINESS

Dr. Lowell W. Painter, chairman, reported that the Reference Committee on Rules and Order of Business had no report to make. He stated, however, that the members of the reference com-

mittee would like to make note of the fact that from time to time resolutions are presented that are not in order, and this causes a great deal of difficulty. Dr. Painter asked that the membership read the rules set out in the Bylaws concerning the introduction of resolutions.

## MEDICAL EDUCATION AND HOSPITALS

The following matters were referred to the Reference Committee on Medical Education and Hospitals. All reports will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association*, with the exception of the report of the State Board of Medical Registration and Examination, which is printed below. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Education and Licensure (pages 1035-1036)
Commission on Special Activities (page 1036)
State Board of Medical Registration and Examination report
Resolution No. 13—REPORT OF PRESIDENT'S COMMISSION ON HEART DISEASE, CANCER AND STROKE
Resolution No. 23—EXPANSION OF INDIANA'S MEDICAL EDUCATION FACILITIES

### *REFERENCE COMMITTEE ACTION*

Dr. John W. Beeler, chairman, presented the following report:

### Medical Education

The reference committee first reviewed the report of the Commission on Medical Education and Licensure (pages 210-212 in Handbook).

We wish to add emphasis to the Preceptorship Program and urge prompt implementation and expansion. Several who appeared before the committee pointed out the need for additional volunteers for this very worthwhile program. We commend the commission for its work this past year.

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded by many, put to vote, and carried.)**

### Special Activities

The reference committee next reviewed the report of the Commission on Special Activities (pages 212-213 in Handbook). It is suggested that a joint liaison committee of the Indiana State Medical Association and the State Bar Association be activated for the purpose of providing a panel of impartial medical witnesses and other items of mutual interest. It is obvious that the commission experienced considerable difficulty in getting the bar association to meet for implementation of the "Impartial Medical Witness" program.

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded by many, put to vote, and carried.)**

### Report of Board of Medical Registration and Examination

| | |
|---|---|
| Number of medical candidates who took the examination* | 244 |
| Number of medical candidates who failed the examination* | 37 |
| Number of medical candidates who failed in one subject only* | 9 |
| Number of medical candidates from foreign medical schools who took the examination | 60 |
| Number of medical candidates from foreign medical schools who failed the examination | 36 |
| Number of candidates who took the special chiropractic examination | 2 |
| Number of candidates who failed the special chiropractic examination | 0 |
| Number of candidates who took the regular chiropractic examination | 0 |
| Number of candidates who failed the regular chiropractic examination | 0 |
| Number of candidates who took the physical therapy examination | 0 |
| Number of candidates who failed the physical therapy examination | 0 |
| Number of medical applicants granted license in Indiana by endorsement/reciprocity | 122 |
| Number of osteopathic applicants granted license in Indiana by endorsement/ reciprocity | 11 |
| Number of medical applicants who were endorsed to other states | 187 |
| Number of osteopathic applicants who were endorsed to other states | 2 |
| Number of applicants granted physical therapy license in Indiana ** by endorsement/reciprocity | 7 |
| Number of applicants granted chiropractic license in Indiana by *** endorsement/reciprocity | 18 |
| Number of citations during the year (all physicians) | 2 |
| Number of revocations during the year (all physicians) | 1 |
| Number of physicians who voluntarily surrendered their Narcotic Stamps to the Internal Revenue Dept., Post Office | 3 |

P. T. Lamey, M.D., *Secretary*
Board of Medical Registration and Examination of Indiana

* Includes foreign graduates.

** Physical therapists by endorsement (10/1/64 to 10/1/65)

*** Chiropractors by endorsement (10/1/64 to 10/1/65)

### *REFERENCE COMMITTEE ACTION*

Dr. John W. Beeler, chairman, presented the following report:

The reference committee next reviewed the report of the State Board of Medical Registration and Examination presented at the first meeting

of the House of Delegates.

We commend the Board of Medical Registration and Examination for its efforts toward implementing the three bills of the 1965 State Legislature: Temporary license for visiting professors; temporary medical permits for interns and residents and greater latitude in potential use of the National Boards of Medical Examination.

There was much discussion about the acute shortage of physicians in general, but particularly those in less populated areas. This problem of supplying doctors in the rural areas must be met and implementation of good resident and intern programs in our larger cities should help to keep more doctors from leaving the state.

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded by many, put to vote, and carried.)**

## Resolution No. 13

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** REPORT OF PRESIDENT'S COMMISSION ON HEART DISEASE, CANCER AND STROKE

WHEREAS, the President's Commission on Heart Disease, Cancer and Stroke has recommended sweeping changes in the existing pattern of medical education, research, and patient care, including the establishment of regional centers for diagnosis, treatment and research, and,

WHEREAS, through a constantly improving pattern of the finest medical education and research in the world, and postgraduate education and improved diagnostic and therapeutic techniques, the American physician is prepared to render the best medical care,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association conduct conferences with medical educators and scientists, medical staffs of hospitals, medical society representatives, and other interested parties, for the purpose of exchanging information and for the development of such recommendations as may be appropriate for the continued improvement of medical education, research, and patient care,

AND BE IT FURTHER RESOLVED, that the Indiana Medical Association report findings and recommendations resulting from these conferences to the AMA Board of Trustees for the information of the board, the councils, and the association members.

### *REFERENCE COMMITTEE ACTION*

Dr. John W. Beeler, chairman, presented the following report:

The reference committee next reviewed Resolution No. 13 concerning the Report of the President's Commission on Heart Disease, Cancer and Stroke. After hearing lengthy discussions, it was the feeling of the reference committee that Resolution No. 13 should be adopted. It is thought essential that organized medicine assume an active role in determining the direction of these programs. This role should be jointly shared with the medical school or schools.

Mr. President, I move the adoption of this portion of the report.

**(Motion duly seconded, put to vote, and carried.)**

## Resolution No. 23

**Introduced by:** THE COUNCIL

**Subject:** EXPANSION OF INDIANA'S MEDICAL EDUCATIONAL FACILITIES

WHEREAS, Indiana's growing population and expanding economy have created an increasing demand for health care services, and,

WHEREAS, despite the splendid efforts of faculty and administration, the Indiana University School of Medicine, one of the largest of such schools in America, cannot train the number of physicians who will be needed in our state in future years or who will constitute our state's contribution to the national pool of physicians,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urge the proper authorities of the state of Indiana to take appropriate steps as soon as possible to bring about the orderly expansion of opportunities for medical education through the establishment of additional geographically distributed medical schools.

### *REFERENCE COMMITTEE ACTION*

Dr. John W. Beeler, chairman, presented the following report:

The reference committee next reviewed Resolution 23 concerning "Expansion of Indiana's Medical Educational Facilities."

Testimony before the reference committee was unanimously in favor of Resolution No. 23. However, in order that Resolution No. 23 cannot be misconstrued as an effort to jeopardize the strengthening of the present medical school, we offer the following amendment, that the words: "and be it further resolved that a further and continued strengthening of the Indiana University School of Medicine is needed" be added at the end of the resolution.

Mr. President, I move the adoption of this amendment to this resolution.

**(Motion seconded, put to vote, and carried.)**

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded, put to vote, and carried.)**

Mr. President, I move the adoption of this report in full.

**(Motion seconded by many, put to vote, and carried.)**

I want to thank the members of this reference committee, Drs. William Clark, Thomas Moore, Glenn Irwin and John Wilson for their diligent consideration of these matters. In particular, I was most pleased with the informative and cooperative manner of Dean Irwin, whose presence on the committee was invaluable.

## LEGISLATION

The following matters were referred to the Reference Committee on Legislation. All reports will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association.* Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Legislation (pages 1017-18)
Resolution No. 2—NON-PARTICIPATION IN HR-6675
Resolution No. 3—NON-PARTICIPATION IN MEDICARE AND/OR OTHER GOVERNMENTAL MEDICAL PROGRAMS
Resolution No. 4—REALIGNMENT OF PHYSICIAN POLICY RE: THIRD PARTIES
Resolution No. 7—RESOLUTION ON MEDICARE
Resolution No. 21—MILLS BILL, HR-6675
Resolution No. 22—REMUNERATION UNDER PL 89-97

Dr. A. G. Blazey questioned the legality of the form in which the report of the Reference Committee on Legislation was written, charging that the committee had made a composite report rather than accepting or rejecting separately each individual resolution referred to it and that the committee had added several new ideas throughout its report. Dr. Blazey quoted Chapter XXV, Section 1, of the Bylaws and read from the "Guide for Members of the House of Delegates and Reference Committees" the paragraph concerning "Authority of Reference Committees."

Judge Ralph Hamill, as parliamentarian, ruled that the procedure followed by the Reference Committee on Legislation was not illegal, that the House of Delegates could vote to adopt, to reject, or to amend any recommendations made by a reference committee and that an amendment could include a rewriting from start to finish.

**On motion duly made, seconded by many, put to vote and carried, the ruling of the chair that the House of Delegates proceed with the report of the Reference Committee on Legislation as written, in order to expedite the matter, was sustained.**

### *REFERENCE COMMITTEE ACTION*

Dr. James H. Gosman, chairman, presented the following report:

Your reference committee considered and recommends approval of the report of the Commission on Legislation as it appears in the Handbook, page 164. We wish to further emphasize that part of the report which suggests the formation of a semi-permanent group to develop policies and plans for implementing in Indiana the so-called DeBakey bill as finally enacted into law.

Mr. President, I move adoption of this portion of this report.

**(Motion seconded by many, put to vote, and carried.)**

Your reference committee is fully and keenly aware of the grave problems confronting this House of Delegates, many of which were mirrored in resolutions which the committee considered.

Your committee heard many speakers express their views on the several resolutions before this committee. They were unanimous in their concern for the welfare of their patients, maintaining the patient-physician relationship and retaining their freedom to exercise their skill and professional judgment in the care of their patients.

Because the resolutions are practically inseparable by reason of the complexities with which they deal, your reference committee has considered them as a whole.

The committee suggests that this House do likewise and, using the procedure of the House of Delegates of the AMA in special meeting October 2-3, adopt a number of comments, principles and policies which establish the position of the ISMA on the issues.

Before proceeding, however, your committee wants to state unequivocally that its recommendations, and whatever actions you may take, must not be construed, in any way whatsoever, as a reflection of approval of P. L. 89-97, or its philosophies.

It is recommended that physicians clearly fix in mind that Part A of P. L. 89-97 relates primarily to hospital and nursing home care, popularly known as Medicare, and that Part B is a *separate voluntary* program to cover physicians' services only.

Your committee would remind you that P. L. 89-97 is a law, despite our objections to it, and it feels confident that the ISMA will abide by it.

In the meantime, your committee recommends that this House serve notice that it will join in every effort to change the patently objectionable features of Title 18, particularly Parts A & B of the law, to insure that rules and regulations under which it will be administered will include no restrictions to professional freedom and that it will be unrelaxing in seeking its eventual repeal.

Mr. President, we have endeavored to evaluate carefully and objectively the matters before your committee and offer the following recommendations which primarily relate to a combination of Parts A and B of Title 18 of P. L. 89-97.

I. PHYSICIAN-PATIENT RELATIONSHIP. Public Law 89-97 affects the legal, traditional and ethical concepts of the physician-patient relationship.

(1) Legal counsel for the American Medical Association has stated that an individual physician acting independently and not in concert with others can lawfully refuse to accept any person as a patient who is a beneficiary under the program, or he may elect to treat such persons.

I move the House accept this statement for information.

**(Motion duly seconded, put to vote, and carried.)**

The Judicial Council of the AMA on October 1, 1965, rendered the following opinion:

(2) *The Principles of Medical Ethics* are applicable to physicians when they engage in group action as well as when they act individually. Sec-

tion 4 calls upon physicians to observe all laws. Accordingly, medical organizations must be mindful of the possible consequences of the actions they propose, engage in or encourage.

Under ordinary circumstances, the individual physician acting independently, is ethically free to select his patients (See Section 5 of the Principles). (a) He may decline to render medical services to persons covered by the "Health Insurance for the Aged Act." (b) He may choose to treat such persons without charge. (c) He may treat patients with the advance understanding that he will look to them exclusively for payment and that he will or will not in any way help them in obtaining reimbursement for the cost of his services or the cost of associated services.

However, under some circumstances, the physician's freedom to select his patients may be circumscribed by overriding ethical considerations. For example:

a. A physician should respond to any request for his assistance in an emergency.
b. Once having undertaken a case, the physician should not neglect the patient, nor should he withdraw from the case without giving notice sufficient to allow the patient to obtain another physician.
c. If a physician decides not to participate in the Medicare program or decides to limit his participation, he should so advise the patient in advance of treatment. This applies to services rendered by the physician as well as hospital services and other benefits provided under the program.
d. As provided in Section 1 of the *Principles of Medical Ethics*, a physician should not refuse to render medical services to any person if as a result, such person will be unable to get necessary medical care.

It should be noted also that Section 6 of the Principles provides that "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause the deterioration of the quality of medical care." If after regulations are promulgated and the Medicare law becomes effective, the individual physician acting independently and not in concert with others, finds it does tend to impair the free and complete exercise of his medical judgment and skill or to cause a deterioration of the quality of medical care, the individual physician would be justified under this Principle in not participating under the law. The physician is ordinarily free to select his patients, subject to such ethical limitations as previously stated.

We also reaffirm the Bauer Resolution adopted in June, 1961, which reads as follows:

*The Bauer Resolution*

"The House of Delegates of the American Medical Association believes the medical profession will see to it that every person receives the best possible medical care regardless of ability to pay, and it further believes

"That the medical profession will render that care according to the system it believes is in the public interest, and that it will not be a willing party to implementing any system which it believes to be detrimental to the public welfare."

I move that this portion of the report be accepted for the information of the House.

**(Motion duly seconded. Discussed by Dr. Blazey. Motion put to vote, and carried.)**

(3) Mr. President, your reference committee believes that it is desirable for this House to adopt a statement of policy regarding the traditional physician-patient relationship as it relates to Public Law 89-97. We recommend that the following statement be adopted:

The Indiana State Medical Association opposes any program of dictation, interference, or coercion, whether direct or indirect, affecting the freedom of choice of the physician to determine for himself the extent and manner of participation or financial arrangement under which he shall provide medical care to patients under Public Law 89-97.

Mr. President, I move adoption of this statement.

**(Motion seconded by many, put to vote, and carried.)**

II. NON-DISCRIMINATION UNDER FEDERALLY-ASSISTED HEALTH CARE PROGRAMS.

Inasmuch as in some states it has been required that physicians pledge non-discrimination, your reference committee recommends that:

(1) All physicians are hereby informed that the refusal to sign such an oath does not flout the law; and it further recommends
(2) That the House of Delegates direct the officers of this association to oppose actively and forcefully this and any future attempts by HEW or any other Federal agency to impose conditions and pledges upon the medical profession.

Mr. President, I move the adoption of these recommendations.

**(Motion duly seconded. Discussed by Dr. Blazey. Motion put to vote, and carried.)**

III. SEPARATION OF PROFESSIONAL FEES AND HOSPITAL CHARGES.

Hospital-based medical specialists are engaged in the practice of medicine. The fees for the services of such specialists should not be merged with hospital charges. The charges for the services of such specialists should be established, billed and collected by the medical specialist in the same manner as are the fees of other physicians and the Indiana State Medical Association should continue the effort to preclude the inclusion of physicians' services as hospital services in any law.

In addition, inasmuch as great pressure will probably be placed on these specialists, your reference committee further recommends that all physicians back this policy with all proper legal and moral means.

Mr. President, I move the adoption of this statement.

**(Motion seconded, put to vote, and carried.)**

*Part "A" of Title 18 of P. L. 89-97*

Your reference committee next considered a number of items related to the primary subjects under Part A of Public Law 89-97:

IV. CERTIFICATION BY PHYSICIANS.

Your reference committee recommends the adoption of the following statement of policy:

Current practices and customary procedures with respect to certification for hospital admission and care shall be continued.

Mr. President, I move the adoption of this statement.

**(Motion seconded, put to vote, and carried.)**

V. UTILIZATION REVIEW.

We recommend the following statement to the House:

Hospital utilization review committees shall be composed of practicing physicians.

Mr. President, I move the adoption of this statement.

**(Motion seconded, put to vote, and carried.)**

VI. SHORTAGE OF HOSPITAL BEDS.

Inasmuch as it is anticipated that there may develop as a result of the implementation of Public Law 89-97 a shortage of hospital and related facility accommodations, it is recommended that a mechanism be developed under which sufficient accommodations for the acutely ill, injured or those in need of elective procedures will be reserved. Further, it is recommended that this matter be referred to the Council for appropriate action.

Mr. President, I move adoption of this recommendation.

**(Motion seconded, put to vote, and carried.)**

*Part "B" of Title 18 of P. L. 89-97*

With reference to Part B of P. L. 89-97, your committee recommends the following:

VII. BLUE SHIELD AS INTERMEDIARY.

Regulations yet to be promulgated will identify the nature of intermediaries under Public Law 89-97. Your committee offers the following statement:

Blue Shield has, in many areas, demonstrated its ability to provide a competent insurance program. However, the Indiana State Medical Association should leave to the local medical society the expression of any preference for selection of a carrier, and further recommends that any carrier selected should only be chosen if it abides by the principle of "usual and customary fees."

Mr. President, I move the adoption of the preceding statement.

**(Motion seconded, put to vote, and carried.)**

VIII. FEES.

The physicians of this nation have advocated for generations constructive programs for the betterment of the public health.

Physicians have been responsible for the enactment of most of the laws in the interest of health.

The longevity of our people has increased under present-day medical care.

Physicians have, over the years, contributed their services either without charge to those in need when money was not available to pay for their services or at greatly reduced fees to provide the highest quality care for veterans, those on Old Age Assistance and all other tax financed programs.

In spite of the aforementioned charitable activities of physicians to relieve the needs of the sick on a gratuitous or semi-gratuitous basis and in spite of the pre-eminence of the nation's health care under our present fee for service system, there are those who now choose to impose a system of government-dictated medical care, which the physicians have pointed out is dangerous from an economic and quality standpoint.

The government now proposes to pay for the care of all over 65 regardless of need, under an increased tax program, eliminating the classification of needy cases but instead proposes to treat the needy and self-sufficient aged as [economic] equals.

We recommend that physicians inform all third parties that effective January 1, 1966, physicians will participate only on the basis they receive their usual and customary fee for like services as paid for by the private paying patients; and it is further recommended that usual and customary fees be defined as follows:

"*Usual*—The 'usual' fee is that fee usually charged for a given service by an individual physician to his private patient (i.e., his own usual fee).

"*Customary*—A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."

It is further recommended that in the event of a dispute between physicians and carriers with respect to usual and customary fees, such disputes shall be resolved with the participation of the appropriate local medical societies.

Mr. President, I move the adoption of the foregoing statement.

**(Motion seconded.)**

**(Dr. Forrest J. Babb moved that the word "economic" be added after the word "as" and before the last word "equals" in the sixth paragraph under title VIII, making this sentence read "the needy and self-sufficient aged as economic equals." Dr. Babb's motion to amend this section of the report was seconded by many, put to vote, and carried.)**

## *REFERENCE COMMITTEE ACTION*

Dr. James H. Gosman, chairman, continued with the report of the Reference Committee on Legislation:

IX. ASSIGNMENT.

One of the provisions included in the law is to the effect that physicians accepting an assignment of payment must accept the fee fixed by a carrier in accordance with regulations of the federal government as full payment for the service. This is true regardless of the physicians' usual fee, or any contrary agreement made between the physician and patient.

On the other hand, the law does not limit the fee a physician may collect from a patient provided no assignment is involved. After obtaining a receipted bill from the physician, the patient may collect from the carrier in an amount not higher than the fee fixed for such service pursuant to regulations of the federal government.

Your reference committee feels that by accepting an assignment of payment, the physician is subordinated to the dictates of HEW and the carrier, and recommends that physicians bill all patients directly.

Mr. President, I move the adoption of the above recommendation.

**(Motion seconded, put to vote, and carried.)**

X. GENERAL RECOMMENDATIONS.

Your reference committee recommends that a statewide information program in cooperation with the American Medical Association be conducted by the officers, Council and staff of the Indiana State Medical Association, designed to keep the medical profession of Indiana up to date on:

(1) developments concerning Public Law 89-97 as regulations are developed;

(2) the rights and privileges of physicians as well as their responsibilities under existing law.

Also, your committee recommends that the *AMA News* be modified to include a concise four-page newsletter type report on socio-economic developments. Pending AMA adoption of this recommendation, the Indiana State Medical Association should issue at frequent intervals such type information in such a newsletter.

XI. PHYSICIAN RESPONSIBILITY.

Physicians are urged to recognize that organization efforts will be ineffective without the active interest of each physician in keeping himself up to date.

Mr. President, I move the adoption of this statement.

**(Motion seconded by many, put to vote, and carried.)**

XII. UNITY.

Experience in foreign countries shows that individual freedom of physicians can only be maintained by unity.

Mr. President, I move the adoption of this statement.

**(Motion seconded, put to vote, and carried.)**

Mr. President, the policy statements herein presented to the House for its action are intended to respond to the specific problems placed before this reference committee as contained in resolutions Nos. 2, 3, 4, 7, 21 and 22.

## Resolution No. 2

**Introduced by:** LAGRANGE COUNTY MEDICAL SOCIETY

**Subject:** NON-PARTICIPATION IN HR-6675

WHEREAS, the practice of private medicine has provided residents of the United States with the highest quality medical care, and,

WHEREAS, the Mills bill, HR-6675, proposes a government program of socialized hospitalization and medical care of the aged, and,

WHEREAS, such a program would destroy the patient-physician relationship so essential to the best medical care and by regimenting physicians and their patients will lead to inferior medical care, and,

WHEREAS, non-participation means that physicians will continue to serve their patients as before but will refuse to deal with a third party that intrudes into the private relationship between patients and their physicians,

NOW THEREFORE BE IT RESOLVED, that the members of the LaGrange County Medical Society (Indiana) oppose HR-6675 and all similar legislation, and pledge ourselves, individually, not to participate in HR-6675 or any similar legislation, and,

BE IT FURTHER RESOLVED, that all members of the Indiana State Medical Association express the same opposition to this legislation.

## Resolution No. 3

**Introduced by:** MADISON COUNTY MEDICAL SOCIETY

**Subject:** NON-PARTICIPATION IN MEDICARE AND/OR OTHER GOVERNMENTAL MEDICAL PROGRAMS

WHEREAS, the practice of private medicine has provided the residents of the United States with the highest quality medical care obtainable, and

WHEREAS, the Mills bill, HR-6675, proposes a government program of hospital and medical care which must inevitably intrude into and disrupt traditional medical relationships, and

WHEREAS, all such government programs destroy the patient-physician relationship, which we regard as essential to the highest quality medical care, and

WHEREAS, we regard it to be our moral and ethical obligation to take whatever steps may be necessary to protect our patients from such inferior care, and

WHEREAS, non-participation is the only remaining ethical, legal, and morally right method of protecting our patients from such inadequate and inferior care, and

WHEREAS, non-participation requires that we, as physicians, will continue to care for and serve our individual patients, we will refuse to accept government intrusion into the private patient-physician relationship,

NOW THEREFORE BE IT RESOLVED, that the members of the Indiana State Medical Association at its regular meeting, on October 14, 1965, oppose HR-6675 and all similar measures, and

BE IT FURTHER RESOLVED, that we, as individual members of the Indiana State Medical Association, announce our determination to refuse to participate in all such schemes of providing medical care and to encourage all other ethical physicians to do likewise.

## Resolution No. 4

**Introduced by:** THE COUNCIL
**Subject:** REALIGNMENT OF PHYSICIAN POLICY RE: THIRD PARTIES

WHEREAS, the physicians of this nation have advocated for generations constructive programs for the betterment of the public health, and,

WHEREAS, physicians have been responsible for the enactment of most of the laws in the interest of health, and,

WHEREAS, the longevity of our people has increased under present day medical care, and,

WHEREAS, physicians have, over the years, contributed their services either without charge to those in need when money was not available to pay for their services or at greatly reduced fees to provide the highest quality care for veterans; those on Old Age Assistance, and all other tax financed programs, and,

WHEREAS, in spite of the aforementioned charitable activities of physicians to relieve the needs of the sick on a gratuitous or semi-gratuitous basis and in spite of the pre-eminence of the nation's health care under our present fee for service system, and,

WHEREAS, there are those who now choose to impose a system of government dictated medical care, which the physicians have pointed out is dangerous from an economic and quality standpoint, and,

WHEREAS, the government now proposes to pay for the care of all over 65 regardless of need, under an increased tax program, eliminating the classification of needy cases but instead proposes to treat the needy and self-sufficient aged as equals,

THEREFORE BE IT RESOLVED, that the physicians of this state adopt the same position for payment of their services as other purveyors of goods and services under federally-supported programs, and,

BE IT FURTHER RESOLVED, that physicians inform all third parties that effective January 1, 1966, physicians will participate only on the basis they receive their usual and customary fee for like services as paid for by the private paying patients, and,

BE IT FURTHER RESOLVED, that usual and customary fees be defined as follows:

"*Usual*—The 'usual' fee is that fee usually charged, for a given service, by an individual physician to his private patient (i.e., his own usual fee).

"*Customary*—A fee is 'customary' when it is within the range of usual fees charged by physicians of similar training and experience, for the same service within the same specific and limited geographical area (socio-economic area of a metropolitan area or socio-economic area of a county)."

## Resolution No. 7

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY
**Subject:** RESOLUTION ON MEDICARE

WHEREAS, it appears that HR-6675, the Medicare Bill of 1965, will become law, and,

WHEREAS, this is nothing less than a step toward socializing the practice of medicine, and,

WHEREAS, the current Congress refuses to heed the warnings of our profession to the effect that socialized medical care is inferior medical care, as has been proven by its history, and,

WHEREAS, the Daviess-Martin County Medical Society resolved, on 1/30/62, not to participate in medical care bills passed by a thoughtless Congress,

NOW THEREFORE BE IT FURTHER RESOLVED, that the Daviess-Martin County Medical Society in regular session this 19th day of April 1965, requests the Indiana State Medical Association to adopt a similar stand of non-participation in the 1965 Medicare Act.

## Resolution No. 21

**Introduced by:** VIGO COUNTY MEDICAL SOCIETY
**Subject:** MILLS BILL HR-6675

WHEREAS, the Mills Bill HR-6675, the commonly called Medicare Bill, has been enacted by Congress and signed by the President and thus is the law of the land, and,

WHEREAS, it has been stated again and again by congressional leaders and also by White House sources that the purpose of this legislation is to assist those over 65 to meet the cost of hospital and nursing home care and that said legislation does in no way affect the physician, his fees, or his method of practicing the art and science of medicine,

NOW THEREFORE BE IT RESOLVED, that the Vigo County Medical Society recommend to the Indiana State Medical Association and to the American Medical Association that they in turn recommend to their respective members that they cooperate to assist compliance with the Medicare Law and the intent of the law as above stated,

BUT BE IT FURTHER RESOLVED, that these same above-mentioned medical associations recommend to their members that any further extension of above legislation or the enactment of other legislation which would involve the physician, his fees, or encroach upon his free practice of medicine be met immediately as of the date of such legislation by complete non-participation in any federally-controlled medical plans.

## Resolution No. 22

**Introduced by:** THE COUNCIL
**Subject:** REMUNERATION UNDER PL 89-97

WHEREAS, Public Law 89-97—89th Congress, known as Medicare, is scheduled to become effective July 1, 1966, and,

WHEREAS, it is reported one of the provisions included in the law is that "if physicians accept an assignment of payment—they must accept a fee set by the government as full payment; regardless of their usual fee, or any agreement made between the physician and his patient regarding the fee," and,

WHEREAS, "if the physician bills the patient directly, he is entitled to charge and collect his usual fee or a fee agreed to by his patient, the patient then submits a paid receipt to the government for reimbursement under the terms of the law."

NOW THEREFORE BE IT RESOLVED, that the Council of the Indiana State Medical Association check these facts and so advise the members of this association of the provisions of this law in this regard.

### *REFERENCE COMMITTEE ACTION*

Dr. James H. Gosman, chairman, continued with the report of the Reference Committee on Legislation:

Mr. President, I move the adoption of the report as amended as a whole.

**(Motion seconded).** (Discussed by Dr. Roger Roof, who asked if voting "yes" on the report as a whole would mean rejecting resolutions Nos. 2, 3, 4 and 7, or would it mean accepting these resolutions.)

The chairman read from the report of the Reference Committtee on Legislation:

"The policy statements herein presented to the House for its action are intended to respond to the specific problems placed before this reference committee as contained in these resolutions."

The chair then ruled that anyone in the House who wished to express himself either for or against each one of these individual resolutions, would have the privilege of doing so. **(On motion duly made and seconded the House sustained the ruling of the chair.)**

**(Motion to adopt the report of the Reference Committee on Legislation as amended as a whole was put to vote, and carried.)**

Dr. Gosman continued:

Your committee wishes to thank the many members who appeared before the committee for their constructive discussion of these resolutions, and I want to express my appreciation to the members of the committee for their time and the diligent service rendered in the formulation of this report.

With permission of the chairman, Dr. Gosman explained: After studying the resolutions presented to the committee it was obvious that many intermingling problems were involved. I assure you that there was no intent, and there isn't now, of trying to usurp any of the privileges. We felt, in order for us to come out with some stated basic statements of fact in principle, so that you gentlemen might have some answers, as they are understood today by us, to take back to your constituents, that this was primarily the best possible way we could do it. I think, if you will look into the content of this, that it does answer all of the questions involved in the various resolutions.

## PUBLIC RELATIONS

The following matters were referred to the Reference Committee on Public Relations. All reports with the exception of the supplemental report of the Commission on Inter-Professional Relations will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association.* Resolutions introduced before the House and referred to this committee are printed herewith.

Grievance Committee (pages 1013-14)
Medical-Legal Review Committee (no written report)
Commission on Public Information (pages 1018-19)
Commission on Inter-Professional Relations (page 1035) and supplemental report
Commission on Aging (pages 1036-37)
Resolution No. 18—STATE ASSOCIATION OF THE PROFESSIONS
Resolution No. 19—COMMUNITY DEVELOPMENT OF EXPLORER SCOUT PROGRAM

### *REFERENCE COMMITTEE ACTION*

Dr. Frank H. Green, chairman, presented the following report:

Members present were Drs. Frank H. Green, Eugene F. Senseny, George T. Lukemeyer, George W. Willison and William F. Kerrigan.

The members of this committee considered the matters referred to it.

### Grievance Committee

The report of the Grievance Committee as reported on pages 156-157 of the Handbook was studied and accepted, as presented.

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded, put to vote, and carried.)**

### Medical-Legal Review

The reference committee next considered the report of the Medical-Legal Review Committee, and finding no written report in the Handbook and no one present to discuss the findings of this committee, there was no report to consider.

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded, put to vote, and carried.)**

## Public Information

The report of the Commission on Public Information was considered (pages 167-171 of the Handbook). This report was reviewed by the reference committee and we find no reason to change this report. We wish to commend them for their fine work.

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded by many, put to vote, and carried.)**

## Supplemental Report of the Commission on Inter-Professional Relations

### PHYSICIAN-PHARMACIST CODE OF UNDERSTANDING

Indiana State Medical Association

Indiana Pharmaceutical Association

*Preamble*

The purpose of this code of understanding is to restate and reaffirm the ethical principles of each profession and to strengthen relations between doctors of medicine and pharmacists.

This code of understanding is not a pronouncement of law, but constitutes suggested rules of conduct for the members of these two health professions subject to the principles of ethics governing the members of the respective organizations and rules of law prescribed for their individual conduct.

This code constitutes the recognition that physicians and pharmacists are interdependent in serving the patient and have a joint responsibility of educating the public in the proper use and handling of medications.

*Prescribing Medication*

Sec. 1. A prescription is the continuation of the physician's diagnosis and treatment. In order to properly meet the medical needs of the patient, a prescription should be written by the physician and dispensed by the pharmacist with care and in accordance with federal and state laws.

Sec. 2. Both the physician and the pharmacist recognize that the refilling of any prescription constitutes the continuation of the physician's treatment of his patient and therefore, in giving refill authorizations and in refilling prescriptions, the practitioners use the same care and precaution as with a new prescription.

Sec. 3. The physician has the responsibility and prerogative of selecting the medication he prefers. When a brand is not specified, the pharmacist has the responsibility of selecting drugs which in his professional judgment are of good quality.

Sec. 4. The sale or purchase of samples is unethical.

*Dispensing Medication*

Sec. 1. The pharmacist recognizes his obligation to the physician and his patient to compound and dispense prescriptions carefully and accurately as ordered by the physician. Should an occasion arise when the pharmacist might suspect that an error has been made concerning the ingredients, dosage or directions for use, he should consult the prescribing physician for clarification and verification prior to dispensing the prescription. Such consultations should be privately made and the pharmacist shall protect the interest of the patient. Pharmacists recognize that the physician must have the confidence of his patient and that inquiries concerning errors in prescriptions must be treated as confidential matters between practitioners.

Sec. 2. Pharmacists should use extreme discretion in conversing with patrons regarding the composition of their prescriptions and should refrain from speculating with the patient regarding the condition for which the medication is prescribed or the physician's course of treatment. If such questions arise, the pharmacist should diplomatically suggest that the physician is the proper person with whom such matters should be discussed.

Sec. 3. The pharmacist should not diagnose or prescribe, even at the insistence of a patient, but should refer those seeking medical information or attention to a physician of the patient's choice. The sale of reputable proprietary products and home remedies that are approved by the federal Food and Drug Administration for over-the-counter sale shall not be considered counter prescribing by the pharmacist when the patron may request the item for self-medication.

Sec. 4. A physician should not advise a patient as to the exact charge for a prescription any more than a pharmacist should advise a patient of charges for physician's services.

*Freedom of Choice*

Sec. 1. Both professions should strive to afford the patient, at all times, free choice of medical and pharmaceutical services.

Sec. 2. Prescription blanks imprinted with the name of a pharmacy, referral of a patient to a specific pharmacist by a physician or referral of a patron to a specific physician by a pharmacist is construed as limiting freedom of choice. These practices are condemned.

*Physician Dispensing*

Sec. 1. Each profession recognizes that the physician has the right, ethically and legally of supplying his patients with needed drugs, remedies or appliances as long as there is no exploitation of the patient. However, the physician should recognize the specialized education and training of the pharmacist and should utilize his services whenever it serves the best interest of the patient.

*Information Service to Physicians*

Sec. 1. The pharmacist, as a ready and impartial source of drug information, should unhesitatingly make such information available to the physician so that the patient may benefit.

*Patient Communications*

Sec. 1. Knowledge or information acquired by the pharmacist regarding the ailments of the patient are entrusted to his confidence as they are to the physician's and should never be divulged without the patient's consent, unless the practitioner is compelled to do so by law, or in the interest of the patient.

*Consideration and Disposition of Complaints or Disputes*

Sec. 1. Complaints or disputes, including complaints of the violation of the principles of this code are to be referred by the complaining physician or pharmacist to his local professional society whereupon representatives of the respective local societies will attempt to resolve the dispute.

The following report was presented to the Council at its meeting on July 18, 1965, and was accepted by the Council with the recommendation that it be referred to the House of Delegates:

Without attempting to go into ancient historical background concerning the relation between doctors of medicine and osteopaths, the commission feels particular attention should be called to the following significant references and developments:

In 1961, the Judicial Council reported to the AMA House of Delegates that the following significant events had occurred.

The American Hospital Association will now list hospitals having doctors of osteopathy on their medical staffs if the hospital submits evidence of regular care of the patient by the attending physician and of general supervision of the clinical work by doctors of medicine.

In September, 1960, the Joint Commission on Accreditation of Hospitals changed its policy to permit a hospital having an osteopath on its staff to apply for inspection for accreditation, provided it is listed by the American Hospital Association and provided, further, that it meets other eligibility requirements of the Joint Commission on Accreditation of Hospitals. The AMA Judicial Council further stated its belief that the transition presently occurring within osteopathy should be recognized as evidence of an attempt by a significant number of practicing doctors of osteopathy to give their patients scientific medical care and, further, belief that this transition should be encouraged so that an inevitable evolutionary process be expedited.

The Council recommended reappraisal of the AMA policy regarding relationships with doctors of osteopathy and that policy should now be applied individually at a local level according to the facts as they exist.

They specifically recommend that the test now should be: does the individual doctor of osteopathy practice osteopathy or does he, in fact, practice a method of healing founded on a scientific basis. If he practices osteopathy, he practices a cult system of healing, and all voluntary professional associations with him are unethical. If he bases his practice on the same scientific principles as those adhered to by members of the American Medical Association, voluntary professional relations with him should be deemed ethical.

Finally, the AMA Council recommended that the several methods for evaluating the professional, ethical and scientific competence of practitioners of medicine can be used to evaluate the professional competence of doctors of osteopathy.

In October of 1961, the House of Delegates of the Indiana State Medical Association adopted a resolution that the Indiana State Medical Association go on record in declaring that consultation with osteopathic physicians is an accepted procedure in ethical medical practice when so determined at the local level; that the doctor of osteopathy does, in fact, practice a system of healing founded on a scientific basis.

In 1963 the Judicial Council of the AMA again reported that since the 1961 pronouncement by the House of Delegates, action to permit the voluntary association of M.D.'s and D.O.'s has been taken in 15 state medical societies. In addition, a unification of the two professions has been effected in California. There's been some activity to change the prohibition against voluntary association of M.D.'s and D.O.'s in the following eight states: Illinois, Indiana, Minnesota, New Hampshire, Vermont, Virginia, Washington and West Virginia. Almost 90% of the D.O.'s practice in the 38 states which grant unrestricted licenses to osteopaths. The tabulation appended to this same report shows 194 D.O.'s practicing in Indiana.

Now the specific recommendations from the commission for determining on a local level whether or not such an association would be ethical, which was the question given to the commission, are as follows:

If the above background information is accepted and considered, it seems clear that no problem remains specifically regarding M.D., D.O. relationship. The problem which does remain is that of relationship between licensed physicians and service; not only as individual practitioners, but also as potential members of medical societies and hospital staffs. This is not a new problem, and there's long been regulations written and unwritten which are applicable to it. The commission suggests for consideration and amplification the following:

1. Referrals may be made to or accepted from fully-licensed physicians.

2. Experience with such referrals should form a basis for judgment as to continuation of such association. Here to be considered are—a.) The quality of information received or supplied with the referral. This includes history, physical examination, laboratory and x-ray findings, tentative diagnosis and previous treatment. b.) Management of the case after return to the referring physician. c.) Results obtained.

It is to be kept in mind that any referral may and often does involve some educational responsibility on the part of the consultant to the referring physician.

Questions concerning hospital staff membership

and privileges should be subject to the bylaws of the hospital medical staff. While these are no doubt somewhat varied, there is a fairly uniform and well-established pattern. It seems reasonable and desirable that they should require a minimum of one year internship and that department heads of the medical staff should hold an M.D. degree.

It further seems desirable that a specific privilege not be granted unless the candidate has some training and/or experience for it. It is generally accepted that the results of experience with any given procedure be subjected to continuing scrutiny by the staff organization and that substandard results be improved or the privilege revoked. This remains desirable.

I might add it is the hope of the commission that there will be elaboration or alteration as you see fit.

## REFERENCE COMMITTEE ACTION

Dr. Green, chairman, continued with the report of the Reference Committee on Public Relations:

### Inter-Professional Relations

The report of the Commission on Inter-Professional Relations as reported in the Handbook and the two parts of the supplemental report of the commission were considered. The report of the Commission on Inter-Professional Relations as printed on page 210 of the Handbook was accepted as printed.

Mr. President, I move the adoption of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

Supplemental Report No. 1, with reference to the Physician-Pharmacist Code of Understanding, was read and studied by the committee and accepted without change.

Mr. President, I move the adoption of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

The second part of the supplemental report of this commission dealt with the relationship of osteopaths and the medical profession on the hospital staffs. This report was read and studied in its entirety and was accepted by your reference committee with the addition of the following statement, which we felt will answer the request of the Inter-Professional Relations Commission for additional elaboration. The following is submitted by the Reference Committee on Public Relations to be added to the supplemental report of the commission dealing with the osteopathic problem as it relates to hospital staffs:

(Dr. Green here explained that this matter previously had been brought up and it had been talked over, bypassed, and inadequately answered to the cause and concern of people in various parts of the state, and that the intent of the reference committee in adding the following statement to its report was to provide an answer that might be used when this problem arises.)

"Being fully cognizant of our profession's deep regard for professional competence and concern for excellent patient care, it is urged that all hospital staff privileges be granted on the basis of ability and professional skill. These privileges are maintained when continued competence is [administered] determined on periodic re-evaluations. The committee urges that all component medical societies and hospital staffs be appraised of the urgent need to establish standards by which to grant hospital privileges to its medical staff members."

(Dr. Green called attention to the substitution of the word "determined" for "administered" in the above statement, which was an error in writing the report, and the chair accepted this editorial change.)

## REFERENCE COMMITTEE ACTION

Dr. Green, chairman, continued with the report of the Reference Committee on Public Relations:

Mr. President, I move the adoption of the addition to the second part of the supplemental report.

(Discussed by Drs. Reese, Donato, Gosman, Dickerson and Senseny.)

(The chairman instructed Dr. Reese to direct an appropriate inquiry regarding this matter to his councilor and it would be considered.)

(Dr. Green elaborated further on what the intent and purpose of this addended paragraph was saying:

"The intent of this committee, in presenting this, was based upon the information that all tax-supported hospitals, in our understanding, will admit to their staffs, by law, any person holding an unlimited license in the state of Indiana, if they so apply. Now this, we are told, is true. Also, it is our understanding, and particularly my understanding, that in participation of the medicare program it may become necessary for some hospitals who have been operating rather freely with their staff organization to so organize the staff that they will be able to comply with the medicare patients. If this is true, we realize, since most hospitals have accepted Hill-Burton funds, the federal government does have some control over these hospitals and will have if they accept welfare or medicare patients. Therefore, it is very possible, and I think probable, that you should expect that these men holding unlimited licenses will apply for staff privileges. Therefore, if these county medical societies see that the staffs of the hospitals in the county in which they have jurisdiction have the proper organization, then you will be able to supervise these men who apply for staff privileges. This might be very necessary to control your own profession, but we are also thinking about other professions which might be applying. We think this is an aswer that should be given to these men who have been asking for help, and this is the way which we thought would help you most."

(Discussed further by Dr. Reese and Dr. Dalton.)

Dr. Dalton: "Our legal counsel advised us differently. They said, first of all, the state law says that these men have unlimited licenses. They said,

'Change your bylaws to read that they be admitted to a probationary type of staff privilege where they can be supervised.' So therefore, I urge you to go back to your hospital staff and develop such classification of staff privilege that will permit you to admit these men but to supervise their activities. You will find, as time goes on and as the osteopathic schools are upgraded, there are and will be qualified osteopaths, whom you will welcome. Provide, then, for their acceptance, but provide also for the rejection of those who are less qualified."

**(Dr. Green's motion for adoption of the addition to the second part of the supplemental report was seconded, put to vote, and carried.)**

### *REFERENCE COMMITTEE ACTION*

Dr. Green, chairman, continued with the report of the Reference Committee on Public Relations:

Mr. President, I move the adoption of this report and the supplement as amended.

**(Motion seconded, put to vote, and carried.)**

## Aging

The report of the Commission on Aging, which appears in the Handbook was studied and accepted by the committee, with the additional comment that the reference committee feels that each county medical society should again be alerted in the very near future to enter into the areawide planning as it concerns the aged.

(With permission of the chair, Dr. Green commented: "We specifically mean that now that the federal government probably will be financing and helping in the building of nursing homes, the control and the planning that goes into these nursing homes in this areawide planning should be investigated and supervised and understood by every county medical society, and we are making a plea here that you get this before your county medical society so that the members will look into this phase of areawide planning.")

### *REFERENCE COMMITTEE ACTION*

Dr. Green, chairman, continued with the report of the Reference Committee on Public Relations:

Mr. President, I move the adoption of this portion of the report with the additional comments by your committee.

**(Motion seconded, discussed by Dr. Hedgcock, put to vote, and carried.)**

## Resolution No. 18

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** STATE ASSOCIATION OF THE PROFESSIONS

WHEREAS, the experience of the Michigan State Medical Society has proved the merit of the establishment of a State Association of the Professions,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association take a leadership role in the formation of an Indiana State Association of the Professions to provide a vehicle for interprofessional cooperation in those areas where united activity of the various professions can be of great benefit.

### *REFERENCE COMMITTEE ACTION*

Dr. Green, chairman, presented the following report:

Next was Resolution No. 18—STATE ASSOCIATION OF THE PROFESSIONS as referred to on pages 113 and 114 of the Handbook.

This resolution was approved as presented. Mr. President, I move the adoption of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 19

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** COMMUNITY DEVELOPMENT OF EXPLORER SCOUT PROGRAM

WHEREAS, mutual benefits are to be gained from the development of Explorer Scout programs, the Indiana State Medical Association reaffirms its long-standing appreciation of the contributions of the Boy Scouts of America, and particularly commends Scouting's Explorer programs for medical specialty posts,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urge component county medical societies to encourage widespread community development of the Explorer Scout program for medical specialty posts in Indiana.

### *REFERENCE COMMITTEE ACTION*

Dr. Green, chairman, presented the following report:

Next was Resolution No. 19—This resolution, COMMUNITY DEVELOPMENT OF EXPLORER SCOUT PROGRAM, appears in the Handbook.

This resolution was approved as presented. Mr. President, I move the adoption of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

Mr. President, I move the adoption of this report as amended in toto.

**(Motion seconded, put to vote, and carried.)**

I wish to thank the members of my committee and those who attended the reference committee meeting.

# HYGIENE AND PUBLIC HEALTH

The following matters were referred to the Reference Committee on Hygiene and Public Health. All reports will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association* with the exception of the Maternal Mortality Study report, copy of which was handed to each delegate. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Public Health (pages 1024-32)
Commission on Voluntary Health Agencies (pages 1033-34)
Maternal Mortality Study report (copy handed to each delegate)
Resolution No. 9—MASS ORAL POLIO ADMINISTRATION
Resolution No. 14—REPRESENTATION ON HILL-BURTON ADVISORY COUNCIL AND AREAWIDE PLANNING AGENCY
Resolution No. 15—CANCER REGISTRIES
Resolution No. 17—PHYSICIAN REPRESENTATION IN FEDERAL HEALTH CARE PROGRAMS
Resolution No. 24—TUBERCULOSIS TESTING

### *REFERENCE COMMITTEE ACTION*

In the absence of Dr. Robert M. Seibel, chairman, Dr. Wilson L. Dalton, member of the Reference Committee on Hygiene and Public Health, presented the following report:

The following reports and resolutions were reviewed and the recommendations are suggested for adoption by the House of Delegates.

## Public Health

This commission is highly commended for the large volume and excellent quality of their labors. It is recommended by this Subcommittee on Industrial Medical Practices and Programs to include the following statement: If a "grievance" examination is requested by the patient, union or lawyer, the examination is not compensable by the insurance carrier or the company. Every attempt should be made to make a fair evaluation.

(Dr. Dalton presented the following revised paragraph, to replace the reference committee's original report on the report of the Commission on Public Health:)

"This commission is highly commended for the large volume and excellent quality of their labors. It is recommended that the Subcommittee on Industrial Medical Practices and Programs include a statement concerning 'grievance' examinations as requested by the patient, union, or lawyer."

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton continued with the report of the Reference Committee on Hygiene and Public Health:

Mr. President, I move the adoption of this portion of the reference committee's report, as amended.

**(Motion seconded, put to vote, and carried.)**

## Voluntary Health Agencies

The reference committee is indebted to Dr. Booher and his members for a fine job. It is urged that every effort be made to implement the formation of an advisory committee as noted on page 207 of the Handbook.

(Dr. Dalton presented the following amended paragraph to replace the above paragraph:)

"The reference committee is indebted to Dr. Booher and the commission for a fine job. It is urged that every effort be made to implement the formation of an advisory committee as recommended on page 207 of the Handbook."

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton continued with the report of the Reference Committee on Hygiene and Public Health:

Mr. President, I move the adoption of this portion of this report, as amended.

**(Motion seconded, put to vote, and carried.)**

## Maternal Mortality Study

It is recommended that every member read this informative report. We suggest that the last statement be deleted because this committee could not discern sufficient data which made this statement meaningful.

(Dr. Dalton presented the following amended paragraph to replace the above paragraph:)

"It is recommended that every member read this informative report. The reference committee suggests that the last statement be deleted because this committee could not discern sufficient data to make this statement meaningful."

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton continued with the report of the Reference Committee on Hygiene and Public Health:

Mr. President, I move the adoption of this section of the report, as amended.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 9

**Introduced by:** HAMILTON COUNTY MEDICAL ASSOCIATION
**Subject:** MASS ORAL POLIO ADMINISTRATION

WHEREAS, in October, 1962, the House of Delegates of the Indiana State Medical Association approved the policy concerning oral polio immunization:

(1) That oral immunization programs presently in progress be completed, except that Type III oral vaccine be withheld from adults.
(2) That new mass oral immunization programs are not encouraged except in epidemics or special local situations.

NOW THEREFORE BE IT RESOLVED, that subsequent studies and immunization programs on the safety and effectiveness of oral polio immunization find this policy to be no longer appropriate and that mass immunization may and should be considered on a county or city level.

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton presented the following report:

*Resolution No. 9*—MASS ORAL POLIO ADMINISTRATION. It is recommended that this

resolution be amended by deleting the words "may and should" and substituting therefor the word "can," and the addition of "by the county medical society." Said resolution would then read as follows:

NOW THEREFORE BE IT RESOLVED, that subsequent studies and immunization programs on the safety and effectiveness of oral polio immunization find this policy to be no longer appropriate and that mass immunization can be considered on a county or city level by the county medical society.

Mr. President, I move the adoption of this portion of this report as amended.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 14

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** REPRESENTATION ON HILL-BURTON ADVISORY COUNCIL AND AREAWIDE PLANNING AGENCY

WHEREAS, the Indiana State Medical Association has inadequate representation on the Hill-Burton Advisory Council for Indiana and on our Areawide Planning Agency,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association make every effort to provide adequate physician representation on the Hill-Burton Advisory Council for Indiana and on our Areawide Planning Agency.

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton presented the following report:

*Resolution No. 14*—REPRESENTATION ON HILL-BURTON ADVISORY COUNCIL AND AREAWIDE PLANNING AGENCY. This is a good resolution and was approved by this reference committee.

Mr. President, I move the adoption of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 15

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** CANCER REGISTRIES

WHEREAS, the protection and the improvement of the health of the American people are basic objectives of the American Medical Association and its component medical societies, and,

WHEREAS, cancer registries provide significant contributions to the advancement of scientific knowledge in the control of cancer,

NOW THEREFORE BE IT RESOLVED, that medical staffs and county medical societies in Indiana be urged to encourage the establishment, maintenance and proper use of cancer registries in hospitals.

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton presented the following report:

*Resolution No. 15*—CANCER REGISTRIES. This is a worthwhile resolution and was approved by this reference committee.

Mr. President, I move the adoption of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 17

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County

**Subject:** PHYSICIAN REPRESENTATION IN FEDERAL HEALTH CARE PROGRAMS

WHEREAS, there is a real need for competent advice by physicians practicing in the community on federal health care plans conducted locally,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association seek the provision for and the appointment of representative physicians as advisory committees in all federal programs which relate to health care.

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton presented the following report:

*Resolution No. 17*—PHYSICIAN REPRESENTATION IN FEDERAL HEALTH CARE PROGRAMS. We agree with this resolution that physician representation in this program is essential. This resolution was approved by this reference committee.

Mr. President, I move the adoption of this portion of the report.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 24

**Introduced by:** MARION COUNTY MEDICAL SOCIETY, Dr. Dwight Schuster

**Subject:** TUBERCULOSIS TESTING

WHEREAS, that maintenance and improvement of public health are important aspects of the medical profession's role, and,

WHEREAS, preventative medicine is becoming more and more important in the maintenance of public health, and,

WHEREAS, the earlier in life that programs designed to uncover public health problems can be instituted, the more effective the eradication of such problems can be,

NOW THEREFORE BE IT RESOLVED, that the physicians of Indiana go on record as favoring the testing of children for tuberculosis as a prerequisite of admission to school.

### *REFERENCE COMMITTEE ACTION*

Dr. Dalton presented the following report:

*Resolution No. 24*—TUBERCULOSIS TESTING. This is a worthy resolution and we approve the favoring of the testing of children for tuberculosis before admission to school. This resolution was approved with the deletion of the words "as a prerequisite of" and substituting the word "before." This resolution would then read:

"NOW THEREFORE BE IT RESOLVED, that the physicians of Indiana go on record as favoring

the testing of children for tuberculosis before admission to school."

Mr. President, I move the adoption of this section of the report of this committee, as amended.

**(Motion seconded, put to vote, and carried.)**

Mr. President, I move the adoption of the report of the Reference Committee on Hygiene and Public Health as a whole, as amended.

**(Motion seconded, put to vote, and carried.)**

## AMENDMENTS TO CONSTITUTION AND BYLAWS

The following matters were referred to the Reference Committee on Amendments to Constitution and Bylaws. All reports will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association*. Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Constitution and Bylaws (pages 1016-17)

Resolution No. 8—CREATION OF SECTION ON PEDIATRICS

Resolution No. 11—RESOLUTIONS TO BE INTRODUCED AT ANNUAL CONVENTION

### *REFERENCE COMMITTEE ACTION*

Dr. Gordon S. Fessler, chairman, presented the following report:

The Reference Committee on Amendments to Constitution and Bylaws met at 9:00 a.m., October 12, 1965. Members present were Gordon S. Fessler, M.D., chairman; Thomas D. Armstrong, M.D.; Floyd A. Boyer, M.D.; Joe Dukes, M.D., and Paul W. Sparks, M.D.

### Report of Commission on Constitution and Bylaws

The report of the Commission on Constitution and Bylaws, beginning on page 162 of the Handbook, was studied and discussed and they wish to make the following report:

### Future Planning Committee

The recommended amendment to Chapter VIII, Sec. 1 of the Bylaws is approved. Said Section 1, as so amended, will then read:

"Section 1. The work of the Association, the performance of which is not provided for elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Council or of the House of Delegates, or by special committees created by the Executive Committee, the Council, or the House of Delegates, shall be performed by the following standing committees and commissions:

The Executive Committee
The Grievance Committee
The Student Loan Committee
The Medical-Legal Review Committee
The Future Planning Committee
The Commission on Convention Arrangements
The Commission on Constitution and Bylaws
The Commission on Legislation
The Commission on Public Information
The Commission on Governmental Medical Services
The Commission on Public Health
The Commission on Voluntary Health Agencies
The Commission on Medical Economics and Insurance
The Commission on Inter-Professional Relations
The Commission on Medical Education and Licensure
The Commission on Special Activities
The Commission on the Aged and Aging

The difference between committees and commissions is shown in the provision of these Bylaws pertaining to their work and composition."

(Mr. President, I move the above amendment to said Bylaws be adopted).

**(On a roll call vote of 79 to 0, the amendment to Chapter VIII, Sec. 1 of the Bylaws was adopted.)**

(The chairman here announced that the House had four more amendments to the Bylaws to be voted upon by roll call and asked for a motion to expedite this matter. **Following discussion by many, on advice of the legal counsel, it was taken by consent that one roll call would be taken, with each delegate voting on the call of his name, on each of the following four amendments:**

(1) Organization and function of Future Planning Committee
(2) Transfer of Newton County from Tenth to Ninth District
(3) Oath of office for incoming association officers
(4) Creation of Section on Pediatrics.

### *REFERENCE COMMITTEE ACTION*

Dr. Fessler, chairman, continued with the report of the Reference Committee on Amendments to Constitution and Bylaws:

### Organization of Future Planning Committee

The committee next considered the recommendations of said commission for the amendment of Chapter XIV of the Bylaws. This will be a new chapter of the Bylaws and will read as follows:

"Chapter XIV, Section 1. The Future Planning Committee shall consist of nine members to be appointed by the President for terms of three years. Terms shall be staggered so that three members' terms expire each year; at the first, three members shall be appointed for one year, three for two years and three for three years. Thereafter all appointments shall be for a period of three years. The President, President-elect, Chairman of the Council, Chairman of the Executive Committee and Editor of *The Journal* shall be ex-officio members. The membership should be varied, according to experience, age, size of local county medical society and geographical area. At least one-third to one-half should be in the age group who would be in practice in the future contemplated, that is ten to twenty years distant.

"Sec. 2. The function of this committee shall be to study and anticipate future trends and to stimulate the various commissions in coordinated directions so there is concord to the entire operation of Indiana State Medical Association. It is not contemplated that it be an operational committee." (Present Chapter XIV be re-numbered Chapter XV and all other chapters re-numbered in the appropriate numerical order.)

## Transfer of Newton County

The committee next considered the said commission's recommended amendment to Chapter XXVII, Sec. 2, and approved said recommended amendment. Said Section 2 of said chapter of the Bylaws will then read as follows:

"Sec. 2 — The state shall be divided into thirteen (13) councilor districts with the boundary lines and numbers of each district to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Bartholomew and Brown counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock counties.

Seventh District—Morgan, Johnson, Marion and Hendricks counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton, White and Newton counties.

Tenth District—Jasper, Porter and Lake counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami and Cass counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart counties."

## Oath of Office

This committee next considered the report of said commission concerning the administering of an oath of office to incoming officers of the association and its recommendation that Chapter V of the Bylaws be amended by adding a new Section 5 to read as follows:

"Section 5. The officers of the Association shall be installed by taking the following oath of office: I, _____solemnly swear that I shall carry out to the best of my ability the duties of the office of the Indiana State Medical Association to which I have been elected.

I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to do the task of bringing increasingly improved medical care within the reach of every citizen.

I shall uphold the Constitution of the United States of America and of the state of Indiana, the Constitution and Bylaws of the American Medical Association and the Constitution and Bylaws of the Indiana State Medical Association at all times.

I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations, I pledge myself, so help me God."

## Provisional Membership

The report of said commission concerning a provisional two-year membership was discussed. Texas and Kentucky have such a provision and these have been studied extensively. This is a matter of such importance that the Commission on Constitution and Bylaws has appointed a subcommittee to further study the proposal and said commission hopes to be able to report their findings at the 1966 meeting. We approve this part of the report of such commission.

Mr. President, I move that this portion of this report be approved.

**(Motion seconded; discussed by Drs. Don Wood and Robert A. Hedgcock; motion put to vote, and carried.)**

## Grievance Committee

The committee next considered the report of said commission relative to changing the name of the Grievance Committee and the report of said commission that said name should not be changed. The reference committee approved this recommendation.

Mr. President, I move that this portion of this report be approved.

**(Motion seconded, put to vote, and carried.)**

## Amendments to Constitution

Your committee considered the part of said commission's report relative to the amendments to the Constitution and approved the same. Said amendments will have to lay over for adoption at the 1966 session of the House of Delegates and cannot be voted upon at this session.

Mr. President, I move the approval of this portion of the report.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 8

**Introduced by:** PETER PETRICH, M.D., Councilor, Ninth District Medical Society

**Subject:** CREATION OF SECTION ON PEDIATRICS

WHEREAS, the Indiana Chapter, American

Academy of Pediatrics is composed of in excess of 100 active members who are members of their component county medical societies and the Indiana State Medical Association, and,

WHEREAS, these members have met almost annually for a luncheon and scientific program, and,

WHEREAS, they have and will take active part in the scientific portion of the annual convention of the Indiana State Medical Association, and,

WHEREAS, the members of the Indiana Chapter, American Academy of Pediatrics at their annual meeting in 1965 approved requesting formulation of a section of the association—a Section on Pediatrics—in accordance with Article VII of the Constitution of the Indiana State Medical Association and under Chapter III, Section 1 of the Bylaws of the Association,

NOW THEREFORE BE IT RESOLVED, that a Section on Pediatrics be hereby approved and provided for by amendment of Chapter III, Section 1 of the Bylaws.

## *REFERENCE COMMITTEE ACTION*

Dr. Fessler, chairman, continued with the report of the Reference Committee on Amendments to Constitution and Bylaws:

### Section on Pediatrics

The committee then discussed Resolution No. 8 which appears in the Handbook beginning on page 108 and approved the same. This resolution provides for an amendment to Chapter III, Section 1 of the Bylaws. Said Section 1, as so amended, will then read:

"Section 1. During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical.
b. Internal Medicine.
c. Eye, Ear, Nose, and Throat.
d. Anesthesia.
e. General Practice.
f. Obstetrics and Gynecology.
g. Preventive Medicine and Public Health.
h. Radiology.
i. Nervous and Mental Diseases.
j. Pathology
k. Pediatrics
l. Any other sections that hereafter may be provided for by the House of Delegates."

### Resolution No. 11

**Introduced by:** FORT WAYNE MEDICAL SOCIETY

**Subject:** RESOLUTIONS TO BE INTRODUCED AT ANNUAL CONVENTION

WHEREAS, publication of resolutions, many of which will not receive an affirmative vote by the House of Delegates of the Indiana State Medical Association, and the intent of many of which might be misconstrued by non-medical persons, in *The Journal of the Indiana State Medical Association* may create unfavorable impressions in the minds of the many non-medical persons who have access to *The Journal*, and,

WHEREAS, few county medical societies meet and transact business during the summer months so that the preparation of resolutions to come before the House of Delegates, and the forwarding thereof to the headquarters office of the Indiana State Medical Association prior to August 1st of each year may result in hastily and inadequately prepared resolutions,

NOW THEREFORE BE IT RESOLVED, that Chapter IV, Section 7, of the Bylaws of the Indiana State Medical Association be amended so that in paragraphs one and two the words "forty-five" shall be deleted and replaced by the word "twenty", and,

BE IT FURTHER RESOLVED, that the headquarters office of the Indiana State Medical Association shall prepare by lithotyping or a similar system of reproduction, and shall mail to each of its physician members and to each county society office, a copy of the resolutions received no later than twelve days prior to the regular annual meeting of the House of Delegates of the association.

## *REFERENCE COMMITTEE ACTION*

Dr. Fessler, chairman, continued with the report of the Reference Committee on Amendments to Constitution and Bylaws:

This committee then considered Resolution No. 11, which appears on page 110 of the Handbook. This resolution was discussed and it was decided by this committee that said resolution should not be approved.

Mr. President, I move the approval of this portion of this report.

**(Motion seconded. Discussed by Drs. Harold Richmond, Fessler, Hedgcock, Milton F. Popp, Dalton, Eugene Senseny, and Mr. Waggener. On voting, the House sustained Dr. Fessler's motion for approval of this section of the reference committee's report which rejected Resolution No. 11.)**

**(At this time, on roll call vote, the House adopted the four amendments to the Bylaws which the chairman had enumerated earlier in the meeting.)**

## ROLL CALL VOTES ON AMENDMENTS TO ISMA BYLAWS

Amendment No. 1—Chapter VIII, Sec. 1, adding Future Planning Committee

Amendment No. 2—Chapter XXVII, Sec. 2, transfer of Newton County from Tenth to Ninth District

Amendment No. 3—Chapter XIV, Sec. 1 and Sec. 2—Organization and Functions of Future Planning Committee

Amendment No. 4—Chapter V, Sec. 5—Administration of Oath of Office to Incoming Officers of Association

Amendment No. 5—Chapter III, Sec. 1—Creation of Section on Pediatrics

(D) Delegate
(A) Alternate
A = Aye
N = Nay
NV = Not voting or absent

| COUNTY | DELEGATE | Amend-ment No. 1 | Amend-ment No. 2 | Amend-ment No. 3 | Amend-ment No. 4 | Amend-ment No. 5 |
|---|---|---|---|---|---|---|
| ADAMS | John E. Doan (D) | NV | A | A | A | A |
| ALLEN | Eugene F. Senseny (D) | A | A | A | A | A |
| | William A. Kleifgen (D) | NV | A | A | A | A |
| | W. Lloyd Bridges (D) | NV | NV | NV | NV | NV |
| | Charles H. Aust (D) | A | A | A | A | A |
| | Richard G. Fullam (D) | NV | NV | NV | NV | NV |
| | Edward D. Miller (D) | A | NV | NV | NV | NV |
| BARTHOLOMEW-BROWN | Harold W. Richmond (D) | A | A | A | A | A |
| | Robert M. Seibel | NV | NV | NV | NV | NV |
| BENTON | D. L. McKinney (D) | A | A | A | A | A |
| BOONE | Clarence G. Kern (D) | NV | A | A | A | A |
| CARROLL | T. Neal Petry (D) | A | A | A | A | A |
| CASS | Earl W. Bailey (D) | A | A | A | A | A |
| CLARK | Joel Carney | NV | NV | NV | NV | NV |
| CLAY | Rahim Farid (D) | A | A | A | A | A |
| CLINTON | Robert A. Hedgcock (D) | A | A | A | A | A |
| DAVIESS-MARTIN | A. G. Blazey (D) | NV | NV | NV | NV | NV |
| | E. B. Lett | NV | NV | NV | NV | NV |
| DEARBORN-OHIO | Leslie M. Baker (D) | A | A | A | A | A |
| | Gordon S. Fessler (D) | A | A | A | A | A |
| DECATUR | Robert Acher (A) | A | A | A | A | A |
| DE KALB | Bradley Hughes (D) | A | A | A | A | A |
| DELAWARE-BLACKFORD | Thomas M. Brown (D) | A | A | A | A | A |
| | Glynn Rivers (D) | A | A | A | A | A |
| | Richard Ingram (A) | NV | NV | NV | NV | NV |
| DUBOIS | John Barrow | NV | NV | NV | NV | NV |
| ELKHART | Edward G. Dovey (D) | NV | NV | NV | NV | NV |
| | Burton E. Kintner (D) | A | A | A | A | A |
| FAYETTE-FRANKLIN | William F. Kerrigan (D) | A | A | A | A | A |
| | Herbert N. Smith | NV | NV | NV | NV | NV |
| FLOYD | Donald LaFollette (D) | A | NV | NV | NV | NV |
| FOUNTAIN-WARREN | Lowell Stephens (D) | NV | NV | NV | NV | NV |
| | Max Hoffman (D) | NV | NV | NV | NV | NV |
| FULTON | Dean K. Stinson (D) | NV | NV | NV | NV | NV |
| GIBSON | R. E. Weitzel | NV | NV | NV | NV | NV |
| GRANT | Robert M. Brown (D) | A | A | A | A | A |
| GREENE | Sam Rotman (D) | NV | NV | NV | NV | NV |
| HAMILTON | Adrian Lanning (A) | A | NV | NV | NV | NV |
| HANCOCK | Wayne Endicott (D) | A | A | A | A | A |
| HARRISON-CRAWFORD | Samuel W. Martin (D) | NV | NV | NV | NV | NV |
| | Jesse Benz | NV | NV | NV | NV | NV |
| HENDRICKS | Malcolm O. Scamahorn (D) | A | A | A | A | A |
| HENRY | Kenneth G. Hill (D) | A | NV | NV | NV | NV |
| HOWARD | Warren McClure (D) | A | A | A | A | A |
| HUNTINGTON | R. W. Wagner (D) | A | A | A | A | A |

| COUNTY | DELEGATE | Amend-ment No. 1 | Amend-ment No. 2 | Amend-ment No. 3 | Amend-ment No. 4 | Amend-ment No. 5 |
|---|---|---|---|---|---|---|
| JACKSON- | Harry R. Baxter (D) | A | A | A | A | A |
| JENNINGS | Forrest D. Ellis (D) | NV | NV | NV | NV | NV |
| JASPER | K. R. Ockermann | NV | NV | NV | NV | NV |
| JAY | James Fitzpatrick (D) | A | A | A | A | A |
| JEFFERSON- | Robert O. Zink | NV | NV | NV | NV | NV |
| SWITZERLAND | Noel S. Graves | NV | NV | NV | NV | NV |
| JOHNSON | Joseph Young (D) | A | A | A | A | A |
| KNOX | Herbert O. Chattin | A | NV | NV | NV | NV |
| KOSCIUSKO | William Cron (D) | A | A | A | A | A |
| LA GRANGE | Philip E. Yunker (D) | NV | NV | NV | NV | NV |
| LAKE | C. O. Almquist (D) | NV | NV | NV | NV | NV |
| | Lee Trachtenberg (D) | A | A | A | A | A |
| | George Thegze (D) | NV | NV | NV | NV | NV |
| | M. B. Gevirtz (D) | NV | NV | NV | NV | NV |
| | Michael Shellhouse (D) | NV | NV | NV | NV | NV |
| | P. J. Rosenbloom (D) | NV | NV | NV | NV | NV |
| | H. W. Eggers (D) | NV | NV | NV | NV | NV |
| | Jacob Pruitt (D) | NV | NV | NV | NV | NV |
| LA PORTE | G. O. Larson (D) | A | A | A | A | A |
| | Thomas D. Armstrong (D) | A | NV | NV | NV | NV |
| LAWRENCE | Joseph Dusard (D) | A | A | A | A | A |
| MADISON | R. D. Williams (D) | A | A | A | A | A |
| | A. T. Jones | NV | NV | NV | NV | NV |
| MARION | Harry G. Becker | NV | NV | NV | NV | NV |
| | John W. Beeler (D) | NV | NV | NV | NV | NV |
| | Floyd A. Boyer (D) | A | A | A | A | A |
| | Glenn W. Irwin, Jr. (D) | A | A | A | A | A |
| | George T. Lukemeyer (D) | A | A | A | A | A |
| | Loren H. Martin (D) | A | A | A | A | A |
| | John O. Butler (D) | A | NV | NV | NV | NV |
| | Sprague H. Gardiner | NV | NV | NV | NV | NV |
| | David Hadley (D) | NV | NV | NV | NV | NV |
| | James M. Leffel (D) | NV | NV | NV | NV | NV |
| | Michael W. Manzie | NV | NV | NV | NV | NV |
| | Roland B. Rust, Jr. (D) | A | A | A | A | A |
| | Morris E. Thomas | NV | NV | NV | NV | NV |
| | Albert M. Donato (D) | A | A | A | A | A |
| | Joseph C. Finneran | NV | NV | NV | NV | NV |
| | James H. Gosman (D) | A | A | A | A | A |
| | Myron H. Nourse | NV | NV | NV | NV | NV |
| | Dwight W. Schuster (D) | A | A | A | A | A |
| | Donald E. Stephens (D) | A | NV | NV | NV | NV |
| | Donald E. Wood (D) | A | A | A | A | A |
| MARSHALL | Robert G. Reed (D) | A | A | A | A | A |
| MIAMI | Lloyd L. Hill (D) | A | A | A | A | A |
| MONTGOMERY | Richard R. Eggers | NV | NV | NV | NV | NV |
| MORGAN | Jay Reese (D) | A | A | A | A | A |
| NEWTON | R. S. Yegerlehner | NV | NV | NV | NV | NV |

| COUNTY | DELEGATE | Amend-ment No. 1 | Amend-ment No. 2 | Amend-ment No. 3 | Amend-ment No. 4 | Amend-ment No. 5 |
|---|---|---|---|---|---|---|
| NOBLE | Donald J. Hooker (A) | NV | NV | NV | NV | NV |
| ORANGE | P. T. Hodgin | NV | NV | NV | NV | NV |
| OWEN-MONROE | Harold M. Manifold (D) | NV | NV | NV | NV | NV |
| | Roger Roof (D) | NV | NV | NV | NV | NV |
| PARKE-VERMILLION | W. D. Britton | NV | NV | NV | NV | NV |
| | J. M. Kercheval | NV | NV | NV | NV | NV |
| PERRY | Fred Smith (D) | NV | NV | NV | NV | NV |
| PIKE | Milton H. Omstead | NV | NV | NV | NV | NV |
| PORTER | Jack Dittmer (D) | NV | NV | NV | NV | NV |
| POSEY | L. John Vogel (D) | NV | NV | NV | NV | NV |
| PULASKI | William Thompson | NV | NV | NV | NV | NV |
| PUTNAM | Richard Veach (D) | NV | NV | NV | NV | NV |
| RANDOLPH | Lowell Painter (D) | A | A | A | A | A |
| RIPLEY | Bill E. Freeland (D) | A | NV | NV | NV | NV |
| RUSH | Frank H. Green (D) | A | A | A | A | A |
| ST. JOSEPH | N. D. Sisson (D) | A | NV | NV | NV | NV |
| | R. W. Holdeman (D) | A | A | A | A | A |
| | Raymond E. Nelson (D) | A | NV | NV | NV | NV |
| | Louis F. Sandock (D) | A | A | A | A | A |
| | W. Robert Orr (D) | A | A | A | A | A |
| SCOTT | James A. Sabens | NV | NV | NV | NV | NV |
| SHELBY | Wilson L. Dalton (D) | A | A | A | A | A |
| SPENCER | Michael O. Monar | NV | NV | NV | NV | NV |
| STARKE | Guy B. Ingwell (D) | A | A | A | A | A |
| STEUBEN | Donald G. Mason (D) | NV | NV | NV | NV | NV |
| SULLIVAN | Joe E. Dukes (D) | A | A | A | A | A |
| TIPPECANOE | R. B. Dubois (D) | A | NV | NV | NV | NV |
| | Forrest J. Babb (D) | A | A | A | A | A |
| TIPTON | A. E. Stouder (D) | NV | NV | NV | NV | NV |
| VANDERBURGH | Ray H. Burnikel (D) | NV | NV | NV | NV | NV |
| | J. Guy Hoover | NV | NV | NV | NV | NV |
| | Charles M. Sinn | NV | NV | NV | NV | NV |
| | George W. Willison (D) | NV | NV | NV | NV | NV |
| | John D. Wilson (D) | NV | NV | NV | NV | NV |
| VIGO | Stuart R. Combs (D) | A | A | A | A | A |
| | Thomas J. Conway (D) | A | NV | NV | NV | NV |
| WABASH | Stanley M. Zydlo (D) | A | A | A | A | A |
| WARRICK | Wendell C. Stover (D) | NV | NV | NV | NV | NV |
| WASHINGTON | Irvin Huckleberry | NV | NV | NV | NV | NV |
| WAYNE-UNION | C. G. Clarkson (D) | NV | NV | NV | NV | NV |
| | Glen Ward Lee (D) | A | A | A | A | A |
| WELLS | John F. Phillips (D) | NV | A | A | A | A |
| WHITE | W. Martin Dickerson (D) | A | NV | NV | NV | NV |
| WHITLEY | Thomas Hamilton (D) | NV | NV | NV | NV | NV |

| | | Amend-ment No. 1 | Amend-ment No. 2 | Amend-ment No. 3 | Amend-ment No. 4 | Amend-ment No. 5 |
|---|---|---|---|---|---|---|
| *COUNCILORS* | | | | | | |
| DISTRICT | DELEGATE | | | | | |
| 1st | P. J. V. Corcoran | A | A | A | A | A |
| 2nd | E. T. Edwards | A | A | A | A | A |
| 3rd | Donald M. Kerr | A | A | A | A | A |
| 4th | Robert M. Reid | NV | NV | NV | NV | NV |
| 5th | V. Earle Wiseman | A | A | A | A | A |
| 6th | William R. Tindall | A | A | A | A | A |
| 7th | Albert M. Donato | A | A | A | A | A |
| 8th | Donald R. Taylor | A | A | A | A | A |
| 9th | Peter R. Petrich | A | A | A | A | A |
| 10th | Lowell H. Steen | NV | A | A | A | A |
| 11th | E. S. Rifner | A | A | A | A | A |
| 12th | Milton F. Popp | A | A | A | A | A |
| 13th | Jene R. Bennett | A | A | A | A | A |
| *PAST-PRESIDENTS* | | | | | | |
| | Franklin S. Crockett | | | | | |
| | Herman M. Baker | | | | | |
| | Karl R. Ruddell | | | | | |
| | M. A. Austin | | | | | |
| | Paul D. Crimm | | | | | |
| | W. Harry Howard | | | | | |
| | W. U. Kennedy | | | | | |
| | Elton R. Clarke | | | | | |
| | M. C. Topping | | | | | |
| | Kenneth L. Olson | | | | | |
| | Earl W. Mericle | | | | | |
| | Guy A. Owsley | A | A | A | A | A |
| | Maurice E. Glock | | | | | |
| | Donald E. Wood | A* | A* | A* | A* | A* |

* Recorded in Marion County vote

## *REFERENCE COMMITTEE ACTION*

Dr. Fessler, chairman, continued with the report of the Reference Committee on Amendments to Constitution and Bylaws:

Mr. President, I move the approval of this report in its entirety.

(Dr. Popp: "Before this is passed as a whole **I would like to move that headquarters be instructed not to include the resolutions in the *ISMA Journal* but to publish said resolutions in loose form and distribute same to the delegates in accordance with the provisions of the Bylaws of the ISMA. I was asked to introduce this by headquarters so they will know what to do. I move that that be accepted by the chair and passed by the House of Delegates."**

**(Motion seconded, put to vote, and carried.)**

Dr. Fessler thanked the members who served on his reference committee, and also the members who had served on the Commission on Constitution and Bylaws.

**(Dr. Fessler's motion for adoption of the report of the Reference Committee on Amendments to Constitution and Bylaws as a whole was duly seconded, put to vote, and carried.)**

## INSURANCE

The following matters were referred to the Reference Committee on Insurance. All reports with the exception of the supplemental report of the Commission on Medical Economics and Insurance will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association.* Resolutions introduced before the House and referred to this committee are printed herewith.

Commission on Medical Economics and Insur-

ance (pages 1034-35) and supplemental report
Report of Glen V. Ryan, M.D., president of Blue Shield (handed to each delegate)
Resolution No. 10—SEPARATION OF PROFESSIONAL AND HOSPITAL FEES
Resolution No. 12—OPTIONAL BLUE SHIELD COVERAGE FOR M.D.'s
Resolution No. 16—PAYMENT OF INTERNS AND RESIDENTS BY BLUE SHIELD PLANS
Resolution No. 25—MALPRACTICE INSURANCE

## REFERENCE COMMITTEE ACTION

Dr. Malcolm O. Scamahorn, chairman, presented the following report:

All members of the Reference Committee on Insurance were present at the meeting at 9:00 a.m., Tuesday, October 12, 1965.

### Medical Economics and Insurance

(1) The committee recommended that the report of the Commission on Medical Economics and Insurance be approved as printed on pages 208 and 209 of the Handbook and that the commission be commended.

Mr. President, I move the adoption of this section of this report.

**(Motion seconded, put to vote, and carried.)**

### Supplemental Report of Commission on Medical Economics and Insurance

DIGEST OF PROPOSED DISABILITY INSURANCE PROGRAM

Your Commission on Medical Economics and Insurance has recently completed a two-year research and study of the feasibility of adopting a Disability Income Insurance Program for all members of the Indiana State Medical Association. The recommendation of your commission is the adoption of such a program to be underwritten by the Continental Casualty Company of Chicago and to be administered by J. Russell Townsend, Jr., C.L.U., of Indianapolis.

The recommended program is designed as a supplemental plan to assist in fulfilling the needs of all members. Through the mass purchasing power of your association, the costs have been determined to be reasonable and consistent with the benefits provided. Individual policies provide the basic understructure of a member's protection; your association plan provides supplemental coverage and is available to virtually all members regardless of impairments providing a sufficient enrollment is attained.

The presentation of this program will be done with full respect to the member's position and time, yet sufficient contact is essential in developing substantial enrollment to permit all members an opportunity to consider and apply for the plan. The methods of presentation employed by the administrator will be mail presentation, personal appearances before regional and other meetings and personal interviews when requested by the members.

Some of the reasons that contributed to recommending your program are:

1. It would attract the largest possible enrollment among four classes of your colleagues:
   A. Those desiring supplemental coverage through basic plans;
   B. Those desiring temporary or short-term insurance;
   C. Those desiring a long-range plan; and
   D. Those 70 years or older whose desirability insurance probably expired years previously.
2. The experience and abilities of the plan administrator, J. Russell Townsend, Jr.
3. The experience and specialization of Continental Casualty Company in the underwriting and maintenance of professional insurance.

In the formation of designing a program of insurance for Indiana physicians, the major contributing factor was the knowledge that there is excellent cooperation among members on association matters. Although premiums and benefits are based on sound underwriting and actuarial principles, equally important, the plan is tailor-made to the needs of Indiana physicians.

The administrator's responsibilities contribute greatly to your program: periodic review with your association on experience, presentation of the program and coordination of claim handling and other services; availability of increased benefits when justified and continued enrollment of young colleagues are all essential to the maintenance and success of the plan. In addition, the headquarters of your association and the office of your administrator being in the same locale will assure all members of close contact and prompt service.

Your commission has recommended for approval your program to be administered by J. Russell Townsend, Jr. and underwritten by Continental Casualty Company as the best suited to fulfill the needs of the members of the Indiana State Medical Association.

## REFERENCE COMMITTEE ACTION

Dr. Scamahorn, chairman, presented the following report:

(2) *Supplemental report on Disability Insurance.* The committee approves the proposed disability insurance program, underwritten by the Continental Casualty Company and administered by J. Russell Townsend, Jr., copy of which was mailed to the officers and delegates of the Indiana State Medical Association and to the presidents of the component county medical societies.

Mr. President, I move the adoption of this portion of this report.

**(Motion duly seconded, put to vote, and carried.)**

## Report of President of Blue Shield —

Glen V. Ryan, M.D.

We move the adoption of the report of the president of Blue Shield as stated in the annual Blue Shield report.

Mr. President, I move the adoption of this section of this report.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 10

**Introduced by:** WABASH COUNTY MEDICAL SOCIETY

**Subject:** SEPARATION OF PROFESSIONAL AND HOSPITAL FEES

WHEREAS, the practice of anesthesiology, pathology, physiatry and radiology is the practice of medicine, and,

WHEREAS, the services of physicians in those specialties cannot be considered hospital services, and,

WHEREAS, the practice of allowing the charges by those specialties to be incorporated in the fees charged by the hospital has resulted in (1) a public misconception that the services rendered by those specialties are being provided as part of hospital care and, (2) increasing hospital domination of those specialties,

NOW THEREFORE BE IT RESOLVED, that henceforth, the Indiana State Medical Association recommends that fees of anesthesiology, pathology, physiatry and radiology be charged separately from the fees of the hospitals and that in no event should the fees of those specialties be incorporated with the charges made by a hospital.

### *REFERENCE COMMITTEE ACTION*

Dr. Scamahorn, chairman, presented the following report:

(4) *Resolution No. 10*—SEPARATION OF PROFESSIONAL AND HOSPITAL FEES. We wish to amend resolution No. 10 by adding the following to the last paragraph of the resolution:

"The charges for the services of such specialists should be established, billed and collected by the medical specialists in the same manner as are the fees of other physicians and that the Indiana State Medical Association should continue its effort to exclude the inclusion of physicians' services as hospital services."

Mr. President, I move the adoption of the amendment to this resolution.

**(Motion seconded.)** Discussed by Dr. Stanley Zydlo, who agreed that the amendment recommended by the reference committee should be adopted but that another amendment should be added, reading as follows, **and Dr. Zydlo so moved:**

"It shall be considered unethical for any physician to be involved in any future contractual arrangement of fee for medical service with a hospital henceforth, and those physicians already under such contractual arrangements be ordered to discontinue such arrangement before July 1, 1966, or so be considered unethical."

**(Dr. Zydlo's motion was duly seconded.)** Discussed by Drs. Owsley, Gatzimos (not a delegate but sponsored by Dr. Jene Bennett), Glen Ward Lee, Dalton, Brown, Scamahorn, Edwards, Bennett, Wood, Bridges and the legal counsel.

**(On motion of Dr. Wood, seconded by Dr. Bridges, on standing vote, the House voted to table the additional amendment to Resolution No. 10 as proposed by Dr. Zydlo.)**

Dr. Scamahorn continued with the report of the Reference Committee on Insurance:

Mr. President, I move the adoption of this section of our report, that is, Resolution No. 10, as amended.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 12

**Introduced by:** TIPPECANOE COUNTY MEDICAL SOCIETY

**Subject:** OPTIONAL BLUE SHIELD COVERAGE FOR M.D.'s

WHEREAS, the physicians of Tippecanoe County feel the honored tradition of professional courtesy is a desirable adjunct of our professional ethics and interrelationships, and,

WHEREAS, we feel the practice of extending professional courtesy should be encouraged instead of supplanted, and,

WHEREAS, the existence of medical payments insurance discourages the practice of professional courtesy and often embarrasses both the doctor and his physician-patient,

NOW THEREFORE BE IT RESOLVED, that the Tippecanoe County Medical Society hereby petitions the Indiana State Medical Association House of Delegates and Council to alter our group policy (Blue Cross-Blue Shield #9665) contract with Mutual Hospital Insurance, Inc., so that medical payments insurance is optional instead of mandatory when hospital insurance is purchased, and,

BE IT FURTHER RESOLVED, that each individual should be free to choose his own insurance coverage and that any physician may choose to buy or not buy medical payments insurance as he desires.

### *REFERENCE COMMITTEE ACTION*

Dr. Scamahorn, chairman, continued with the report of the Reference Committee on Insurance:

(5) *Resolution No. 12*—OPTIONAL BLUE SHIELD COVERAGE FOR M.D.'s. This committee commends the intent of Resolution No. 12 and encourages the extension of courtesy privileges as expressed in the resolution. However, we move for the rejection of this resolution.

**(Motion seconded and on standing vote was carried.)**

## Resolution No. 16

**Introduced by:** JAMES H. GOSMAN, M.D., delegate from Marion County
**Subject:** PAYMENT OF INTERNS AND RESIDENTS BY BLUE SHIELD PLANS

WHEREAS, there has been controversy in regard to the payment by Blue Shield Plans for professional services rendered by residents and interns, and,

WHEREAS, it is the policy of the American Medical Association that each physician shall be the sole arbiter of the ways in which he shall dispose of his professional income, consistent with the laws of the land and the Principles of Medical Ethics of the American Medical Association,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association record itself as approving and supporting the principle that Blue Shield medical-surgical benefits should be paid only to private physicians for eligible professional services personally rendered to their private patients, and,

BE IT FURTHER RESOLVED, that the Indiana State Medical Association report its action to the National Association of Blue Shield Plans and to all component county medical societies.

### *REFERENCE COMMITTEE ACTION*

Dr. Scamahorn, chairman, presented the following report:

(6) *Resolution No. 16*—PAYMENT OF INTERNS AND RESIDENTS BY BLUE SHIELD PLANS. The committee approves resolution No. 16 and recommends its adoption.

Mr. President, I move the adoption of this Resolution No. 16.

**(Motion duly seconded. Discussed by Drs. Lukemeyer and Joe E. Dukes. On standing vote the motion to adopt Resolution No. 16 was carried.)**

## Resolution No. 25

**Introduced by:** THE COUNCIL
**Subject:** MALPRACTICE INSURANCE

BE IT RESOLVED, that this House of Delegates rescind its action taken in October, 1944, concerning the approval of the St. Paul Mercury Indemnity Company as the sole, official carrier of malpractice insurance for the membership of the Indiana State Medical Association.

### *REFERENCE COMMITTEE ACTION*

Dr. Scamahorn, chairman, presented the following report:

(7) *Resolution No. 25*—MALPRACTICE INSURANCE. The reference committee believes this resolution should be referred to the Commission on Insurance for further study and that their findings be reported to the next meeting of this House.

Mr. President, I move the adoption of this section of our report.

**(Motion seconded, put to vote, and carried.)**

Mr. President, I move the adoption of this report as a whole, as amended.

**(Motion seconded, put to vote, and carried.)**

# MISCELLANEOUS BUSINESS

The following matters were referred to the Reference Committee on Miscellaneous Business. All reports will be found on the pages indicated in the September, 1965, Vol. 58, No. 9, *Journal of the Indiana State Medical Association.* Resolutions introduced before the House and referred to this committee are printed herewith.

Committee on Student Loan (page 1014)
Commission on Convention Arrangements (no printed report)
Commission on Governmental Medical Services (pages 1019-24)
Building Committee (pages 1014-15)
Resolution No. 1—RESOLUTION AGAINST AREAWIDE HOSPITAL CONTROL
Resolution No. 5—RESOLUTION ON DUES
Resolution No. 6—RESOLUTION AGAINST FEDERAL SUBSIDY OF MEDICAL CARE

### *REFERENCE COMMITTEE ACTION*

Dr. Dwight Schuster, chairman, presented the following report:

## Student Loan

The reference committee commended the Student Loan Committee for their report and recommended continuation of the program with exploration of possible extension for loans to Indiana residents attending out-of-state medical schools and to out-of-state residents attending the Indiana University School of Medicine.

The committee expressed interest in knowing how many loan recipients have remained to practice in Indiana. The suggestions were made with the idea of helping to bring and retain doctors in Indiana.

Mr. President, I move the acceptance of this portion of the report.

**(Motion seconded, put to vote, and carried.)**

## Convention Arrangements

The reference committee appreciated the efforts of the Commission on Convention Arrangements in arranging the 1965 program. The question was raised regarding the program emphasizing one area of medicine and whether or not this might reduce attendance and break the habit of regular attendance by physicians.

It was noted that on Tuesday morning, there was no outside sign at the Murat Temple showing that the Indiana State Medical Association was meeting.

Mr. President, I move the acceptance of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

## Governmental Medical Services

The reference committee reviewed the lengthy report of the Commission on Governmental Medical

Services and appreciated the great effort expended by the members of that commission.

The committee questioned whether the Hospital Disaster Plan Guide had been distributed, and, if not, what distribution would be made, and when? It was recommended that each hospital and each county medical society be given a copy of that guide.

Commendation was given to the subcommittee on Mental Health and the reference committee urged all physicians to participate in the program in their community to aid in medical supervision and guidance of the community mental health center's program.

The reference committee recommended that the director of the State Department of Public Welfare be contacted as to the legal opinion rendered by the attorney general referable to the proposition that there be only one fee schedule for all programs under the State Department of Public Welfare. This recommendation was made in order that the Indiana State Medical Association may be able to negotiate with local welfare boards within a legal framework.

The reference committee commented that the rejection rate on Medicare claims seemed quite high and suggested that efforts be made to alleviate this, possibly through educating physicians more completely as to what is and what is not covered by Medicare. Any other methods to improve the procedure that the administration can suggest should be carried out.

Mr. President, I move adoption of this portion of this report.

**(Motion duly seconded, put to vote, and carried.)**

## Building Committee Report

The Building Committee report was accepted with thanks by this reference committee.

Mr. President, I move the adoption of this portion of this report.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 1

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY

**Subject:** RESOLUTION AGAINST AREAWIDE HOSPITAL CONTROL

WHEREAS, Congress has authorized the appropriation of $22,500,000.00 for a study of areawide hospital planning over a five-year period that started in 1964, and,

WHEREAS, the American Hospital Association Board of Trustees has circulated a folder saying that "The state government should be authorized to deny licenses for projects that are not approved under the regional plan," and,

WHEREAS, the state of New York has already adopted such a dogmatic control in its Metcalf-McClosky Law, and,

WHEREAS, the adoption of such a state law in Indiana would be detrimental to the best type of medical care by virtue of third party political interference,

NOW THEREFORE BE IT RESOLVED, by the Daviess-Martin County Medical Society in regular session this 15th day of February, 1965, that we request the delegates of the 1965 session of the Indiana State Medical Association to pass a resolution against such control of hospitals and related health facilities by any state agency.

## *REFERENCE COMMITTEE ACTION*

Dr. Schuster, chairman, presented the following report:

*Resolution No. 1*—RESOLUTION AGAINST AREAWIDE HOSPITAL CONTROL. Dr. Schuster announced that he had an editorial revision of this section of the reference committee's report which he would read.

Dr. Schuster: "Your reference committee reconvened after receiving supplemental information and voted to reject Resolution No. 1. This was based on further information; namely, that the Indiana State Board of Health is already the licensing agency for hospitals and that experience has indicated that its Section on Area Planning has generally functioned to the satisfaction of the Indiana State Medical Association. Also, to approve this resolution could indicate our indirect approval of a group other than the State Board of Health, which group's philosophy and actions could be injurious to our interests. Therefore, the committee voted to reject the resolution and to affirm our positive liaison with the State Board of Health. We recommend this liaison be continued under observation by the Council of the Indiana State Medical Association."

Mr. President, I move the adoption of this section of the report, as amended.

**(Motion seconded, put to vote, and carried.)**

## Resolution No. 5

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY

**Subject:** RESOLUTION ON DUES

WHEREAS, the five page mailing of September 4, 1964 to all members of the ISMA was replete with needless demands for more operating expenses, and,

WHEREAS, the same mailing could have requested the member's opinion on the plans for expanded activities, and,

WHEREAS, adequate time for exchange of opinions on this matter between county society members was not available for instructions to be given to delegates to the ISMA meeting, and,

WHEREAS, some societies had no delegates representing them at this annual meeting, and,

WHEREAS, the dues increase voted for by the House of Delegates in October, 1964, is but an introduction to further increases to be expected in the future if not now protested,

NOW THEREFORE BE IT RESOLVED, by the members of the Daviess-Martin County Medical Society, in regular meeting this 18th day of January, 1965, that continuation of present dues increase or future dues raising be decided on the basis of a referendum of the entire membership.

### *REFERENCE COMMITTEE ACTION*

Dr. Schuster, chairman, presented the following report:

*Resolution No. 5*—RESOLUTION ON DUES. The reference committee voted to reject this resolution but wishes to commend the Council for sending out advance information relative to dues increase. The committee recommended continued effort be made to improve communication between individual members and the Council through earlier reports to the membership of the Indiana State Medical Association on the matter of changes in annual dues.

Mr. President, I move the adoption of this section of our report.

**(Motion seconded.)**

Dr. Lloyd Hill moved that the following be added to this section of the reference committee's report:

This House of Delegates wishes to again stress the importance of having members present to testify before the reference committees. No member of the sponsoring county was present to testify in behalf of this resolution.

**(Dr. Hill's motion was seconded, put to vote, and carried.)**

Dr. Schuster, chairman, continued with the report of the Reference Committee on Miscellaneous Business:

Mr. President, I move the adoption of this section of the report, as amended.

**(Motion seconded, put to vote, and carried.)**

### Resolution No. 6

**Introduced by:** DAVIESS-MARTIN COUNTY MEDICAL SOCIETY

**Subject:** RESOLUTION AGAINST FEDERAL SUBSIDY OF MEDICAL CARE

WHEREAS, a Supreme Court decision* has said that it is not unreasonable for the Federal Government to control that which it subsidizes, and,

WHEREAS, the AMA delegates in June, 1964, opposed the federal subsidization of pre-payment plans and health insurance companies, and,

WHEREAS, the AMA this year is proposing the passage of an Eldercare Bill that violates the 1964 decision of the House of Delegates,

NOW THEREFORE BE IT RESOLVED, by the Daviess-Martin County Medical Society in official session this 15th day of March, 1965, that we do not sanction this switch in policy adopted by a special session of the House of Delegates of the AMA this year, and request the ISMA to sponsor a resolution at its next annual meeting expressing this opinion.

* Wickard vs. Filburn, 1942.

### *REFERENCE COMMITTEE ACTION*

Dr. Schuster, chairman, presented the following report:

*Resolution No. 6*—RESOLUTION AGAINST FEDERAL SUBSIDY OF MEDICAL CARE. The reference committee voted to reject this resolution because recent legislative action rendered it no longer pertinent.

Mr. President, I move the adoption of this section of the report.

**(Motion seconded, put to vote, and carried.)**

Mr. President, I move the adoption of the report of the Reference Committee on Miscellaneous Business as a whole.

**(Motion seconded, put to vote, and carried.)**

Dr. Schuster: I wish to thank the members of my committee and also the people who came to talk to us.

## ELECTION OF OFFICERS

The following officers were elected:

President-elect—Eugene S. Rifner, M.D., Van Buren

Treasurer—Ottis N. Olvey, M.D., Indianapolis

Assistant Treasurer—Lester H. Hoyt, M.D., Indianapolis

AMA delegates and alternates for term expiring December 31, 1967:

Delegates:

Guy A. Owsley, M.D., Hartford City

Jack E. Shields, M.D., Brownstown

Alternates:

Maurice E. Glock, M.D., Fort Wayne

Dwight W. Schuster, M.D., Indianapolis

## ADDRESS OF PRESIDENT-ELECT

There is no one whose name has been placed in nomination before this body, for this office, who has not given his acceptance speech over and over. Now, I find it a little difficult to do.

First, I wish to thank you for the great honor and trust you have given me. Suddenly, the weight of the office seems heavy upon my shoulders. I pray to God for guidance, for understanding, for foresight and for the wisdom to cope with the problems which are surely to be in store for us. I would pray that we may look to the Indiana State Medical Association for guidance—a positive approach to all problems, and that the organization, through its leaders of the past and present, may foresee many of the difficulties and prepare positive answers to these before this is done for us by some other party. May we stay united—all medicines in Indiana—under one roof.

Emerson has said, "Every sweet has its sour! Every evil its good." Let us look back at that which we thought was evil and find the good and work for the fulfillment of that good. The watchword during my tenure of office will be—United in a positive, forward motion for continued better patient care.

Thank You!

### Places of Future Annual Conventions

Dates and places previously set:

1966—French Lick, October 10, 11 and 12

1967—Indianapolis, October 10, 11 and 12

1968—Fort Wayne. Dates not set

**On motion of Dr. Blazey, duly seconded, French Lick**

was selected as the convention site for the 1969 convention.

On behalf of the Vanderburgh County Medical Society, Dr. Corcoran invited the association to meet in Evansville in 1970. Dr. Corcoran's motion was seconded by Dr. Wendell C. Stover, put to vote, and carried.

The selection of the sites for the 1969 and 1970 conventions was discussed by several. Dr. Ralph Everly, chairman of the Executive Committee, suggested that in order to assure a healthy convention income in alternating years, the House should consider meeting in Indianapolis in 1969, instead of French Lick, and then possibly going to Evansville in 1970.

On motion of Dr. Gosman, seconded by many, the House voted to reconsider the selection of the 1969 convention site.

Dr. Gosman moved that the convention site for 1969 be Indianapolis. Motion duly seconded, and on standing vote the House selected Indianapolis as the place for the 1969 convention and Evansville as the 1970 convention site.

The chairman announced that the following convention sites had been selected:

1969—Indianapolis
1970—Evansville

## Resolutions of Appreciation

*Appreciation of Luncheon Speakers*

Dr. T. Neal Petry presented the following resolution which was adopted unanimously:

WHEREAS, political leaders are overtaxed with public appearances, and,

WHEREAS, these individuals are called upon constantly by many organizations to make speaking engagements, and,

WHEREAS, the appearance of Senator Everett M. Dirksen and Representative Charles A. Halleck at the 116th annual convention of the Indiana State Medical Association added immeasurably to the success of the convention,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association commend and thank the aforementioned gentlemen for their participation in the 116th annual convention of this association and that appropriate notification of said resolution be sent to Senator Dirksen and Congressman Halleck.

*Appreciation of Entertainment and Convention Arrangements Committees*

Dr. W. Lloyd Bridges presented the following resolution which was adopted unanimously:

WHEREAS, the program and entertainment portions of any ISMA convention requires days and days of hard work and preparation, and,

WHEREAS, the program and entertainment provided at the 116th annual convention of the Indiana State Medical Association in conjunction with the American Medical Association's Congress on Occupational Health can be considered one of the most successful programs ever staged for a convention, and,

WHEREAS, without the many hours of work put in by Dr. and Mrs. William Kendrick, co-chairmen of the entertainment committee; Dr. Eli S. Jones, chairman of the AMA Council on Occupational Health; Dr. John Mader and his Commission on Convention Arrangements and the many other physicians and their wives who assisted them, there would not have been such a successful program,

NOW THEREFORE BE IT RESOLVED, that the sincere thanks and appreciation of every member of the Indiana State Medical Association be expressed to these physicians and their wives for the excellent planning and execution of this year's program by the passage of this resolution.

*Appreciation of President*

Dr. Stuart R. Combs introduced the following resolution which was adopted unanimously:

WHEREAS, the Indiana State Medical Association has been fortunate in having Dr. Joseph M. Black as its president this past year, and,

WHEREAS, he has given unstintingly of his time to the affairs of organized medicine, both on a state and national level, with cooperation, vigor and enthusiasm, and,

WHEREAS, as the official spokesman of the association on numerous occasions throughout Indiana and the nation during the past year, he has expressed organized medicine's viewpoint on very important matters, and,

WHEREAS, activity by the Indiana State Medical Association's president is becoming more and more demanding each year, and,

WHEREAS, Dr. Black has met his obligations as president with sincere dedication and purpose,

NOW THEREFORE BE IT RESOLVED, that this House of Delegates recognize with gratitude the work of Dr. Joseph M. Black in behalf of his fellow physicians and extend to him their heartfelt thanks and appreciation for a job exceedingly well done.

## Adjournment

The House of Delegates adjourned, *sine die*, at 7:35 p.m., Thursday, October 14, 1965.

# Annual Audit

The Council
Indiana State Medical Association
Indianapolis, Indiana

We have examined the balance sheet of Indiana State Medical Association as of September 30, 1965, and the related statements of fund surplus and revenues and expenditures for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying balance sheet and statements of fund surplus and revenues and expenditures present fairly the financial position of Indiana State Medical Association at September 30, 1965, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Wolf and Company
Certified Public Accountants

Indianapolis, Indiana
October 20, 1965

## INDIANA STATE MEDICAL ASSOCIATION

### BALANCE SHEETS

September 30, 1965

Exhibit A

### ASSETS

| | | |
|---|---|---|
| **GENERAL FUND:** | | |
| Cash | | 31,926.47 |
| Deposits: | | |
| Postmaster | | 812.73 |
| Air lines | | 425.00 |
| Prepaid expenses | | 1,165.16 |
| Accrued interest receivable | | 1,416.11 |
| Receivable from other funds: | | |
| Student Loan Fund | 6,435.31 | |
| The Journal | 6,101.86 | 12,537.17 |
| Reimbursement due for Medicare expenses | | 7,932.09 |
| Invested funds: | | |
| United States obligations, at cost, less amortization: | | |
| Treasury bonds | 50,000.00 | |
| Savings bond | 10,000.00 | |
| Bills | 45,000.00 | |
| | 105,000.00 | |
| Amortization of premium and discount (net) | 11.55 | |
| | 104,988.45 | |
| Certificate of deposit | 50,000.00 | |
| Savings and loan shares (Note) | 21,366.51 | 176,354.96 |
| Fixed assets: | | |
| Office furniture and equipment | 74,155.89 | |
| Less accumulated depreciation | 27,488.82 | 46,667.07 |
| | | 279,236.76 |
| **BUILDING FUND:** | | |
| Cash | | 403.60 |
| Receivable from general fund | | 5,000.00 |
| Fixed assets: | | |
| Building | 299,354.38 | |
| Less accumulated depreciation | 20,672.82 | 278,681.56 |
| Land | | 69,187.60 |
| | | 353,272.76 |
| **THE JOURNAL:** | | |
| Cash | | 6,463.93 |
| Accounts receivable: | | |
| Advertising | 7,403.48 | |
| Other | 103.43 | 7,506.91 |
| Investment—domestic stock | | 200.00 |
| | | 14,170.84 |
| **MEDICAL DEFENSE FUND:** | | |
| Cash | | 132.13 |
| Accrued interest receivable | | 284.39 |
| Receivable from general fund | | 5,492.80 |
| Investment in U. S. Government obligations | 30,000.00 | |
| Unamortized bond premium | 187.04 | 30,187.04 |
| | | 36,096.36 |
| **STUDENT LOAN FUND:** | | |
| Cash | | 1,144.78 |
| Deposit held in escrow | | 20,810.00 |
| Notes receivable | | 18,690.67 |
| Receivable from general fund—dues allocated | | 19,160.00 |
| Investment—savings and loan shares | | 2,947.03 |
| | | 62,752.48 |
| **MEDICARE FUND:** | | |
| Cash | | 33,495.17 |
| Recoverable payments to doctors | | 26,504.83 |
| | | 60,000.00 |

NOTE:
Savings and loan shares, including dividends, in the total amount of $21,366.51 have been identified for the purpose of liquidating the obligation to the American Medical Education Fund.

## LIABILITIES AND FUND SURPLUS

| | | |
|---|---|---|
| GENERAL FUND: | | |
| Accounts payable: | | |
| Operating expenses | 1,433.78 | |
| American Medical Education Fund | 19,160.00 | 20,593.78 |
| Accrued payroll taxes | | 285.66 |
| Advances from AMA for special advertising | | 10,650.69 |
| Payable to other funds: | | |
| Student Loan Fund | 19,160.00 | |
| Medical Defense Fund | 5,492.80 | |
| Building Fund | 5,000.00 | 29,652.80 |
| Deferred Income: | | |
| Unearned dues | 69,526.31 | |
| Exhibitor's deposits | 16,367.00 | 85,893.31 |
| Deposits on tape recordings | | 415.50 |
| Fund surplus (Exhibit B) | | 131,745.02 |
| | | 279,236.76 |
| BUILDING FUND: | | |
| Loans from members | | 23,875.00 |
| Notes payable—bank | | 36,000.00 |
| | | 59,875.00 |
| Fund surplus (Exhibit B) | | 293,397.76 |
| | | 353,272.76 |
| THE JOURNAL: | | |
| Accounts payable | | 46.36 |
| Accrued payroll taxes | | 46.62 |
| | | 92.98 |
| Payable to general fund | | 6,101.86 |
| Unearned income from dues | | 7,976.00 |
| | | 14,170.84 |
| MEDICAL DEFENSE FUND: | | |
| Fund surplus (Exhibit B) | | 36,096.36 |
| | | 36,096.36 |
| STUDENT LOAN FUND: | | |
| Advanced from general fund | | 25,000.00 |
| Less loans to general fund | | 18,564.69 |
| | | 6,435.31 |
| Fund surplus (Exhibit B) | | 56,317.17 |
| | | 62,752.48 |
| MEDICARE FUND: | | |
| Funds advanced by U. S. Government | | 60,000.00 |
| | | 60,000.00 |

## STATEMENT OF FUND SURPLUS

For the Year Ended September 30, 1965

Exhibit B

| | | |
|---|---|---|
| GENERAL FUND: | | |
| Balance, September 30, 1964 | | 98,981.27 |
| Add: | | |
| Cancellation of prior years' dues liability to American Medical Education Fund | | 210.00 |
| Net income transferred from The Journal | | 6,054.60 |
| Excess of revenues over expenditures: | | |
| Exhibit C | 10,586.43 | |
| Dues allocated for capital expenditures | 15,912.72 | 26,499.15 |
| Balance, September 30, 1965 | | 131,745.02 |
| BUILDING FUND: | | |
| Balance, September 30, 1964 | | 281,074.29 |
| Revenues: | | |
| Dues allocated | 19,225.00 | |
| Donations from members | 150.00 | |
| Special donations | 1,034.00 | 20,409.00 |
| | | 301,483.29 |
| Less: | | |
| Depreciation on building | 5,962.98 | |
| Interest on bank loan | 2,122.55 | 8,085.53 |
| Balance, September 30, 1965 | | 293,397.76 |
| THE JOURNAL: | | |
| Balance, September 30, 1964 | | ..... |
| Excess of revenues over expenditures (Exhibit D) | | 6,054.60 |
| Net income transferred to general fund | | 6,054.60 |
| Balance, September 30, 1965 | | ..... |
| MEDICAL DEFENSE FUND: | | |
| Balance, September 30, 1964 | | 33,068.55 |
| Excess of revenues over expenditures (Exhibit E) | | 3,027.81 |
| Balance, September 30, 1965 | | 36,096.36 |
| STUDENT LOAN FUND: | | |
| Balance, September 30, 1964 | | 54,387.83 |
| Dues allocation of prior year cancelled by House of Delegates | | 18,945.00 |
| | | 35,442.83 |
| Allocation of dues—current period | 19,160.00 | |
| Donation | 1,000.00 | |
| Interest received on student loans | 714.34 | 20,874.34 |
| Balance, September 30, 1965 | | 56,317.17 |

## STATEMENT OF REVENUES AND EXPENDITURES

For the Year Ended September 30, 1965

Exhibit C

GENERAL FUND

| | Actual | Budget | Actual Over (Under*) Budget |
|---|---|---|---|
| Revenues: | | | |
| Dues | 262,256.69 | 272,370.00 | 10,113.31* |
| Less dues allocated: | | | |
| Capital expenditures | 15,912.72 | 15,000.00 | 912.72 |
| Building Fund | 19,225.00 | 18,000.00 | 1,225.00 |
| The Journal | 32,068.00 | 28,800.00 | 3,268.00 |
| Medical Defense Fund | 4,815.25 | 4,320.00 | 495.25 |
| Student Loan Fund | 19,160.00 | 18,000.00 | 1,160.00 |
| American Medical Education Fund | 19,160.00 | 18,000.00 | 1,160.00 |
| | 110,340.97 | 102,120.00 | 8,220.97 |
| Dues available for operations | 151,915.72 | 170,250.00 | 18,334.28* |
| Interest received on investments | 7,061.13 | 3,400.00 | 3,661.13 |
| Received from AMA | 1,687.05 | 1,600.00 | 87.05 |
| Contributions | 1,500.00 | | 1,500.00 |
| Restoration of prior allocation, Student Loan Fund | 18,945.00 | 18,990.00 | 45.00* |
| Miscellaneous | 200.00 | | 200.00 |
| Total revenues | 181,308.90 | 194,240.00 | 12,931.10* |

| | | | |
|---|---|---|---|
| Expenditures: | | | |
| Committees and commissians (Schedule C-1) | 12,594.50 | 25,950.00 | 13,355.50* |
| Officers and council (Schedule C-2) | 25,283.99 | 23,000.00 | 2,283.99 |
| Headquarters office (Schedule C-3) | 119,621.32 | 129,750.00 | 10,128.68* |
| Donations | 3,043.87 | 3,000.00 | 43.87 |
| Emplayees' retirement fund | 8,205.74 | 7,500.00 | 705.74 |
| Excess of expenses over income—annual meeting (Schedule C-4) | 1,973.05 | | 1,973.05 |
| Total expenditures | 170,722.47 | 189,200.00 | 18,477.53* |
| Excess of revenues over expenditures | 10,586.43 | 5,040.00 | 5,546.43 |

## STATEMENT OF OPERATING EXPENDITURES

For the Year Ended September 30, 1965

Schedule C-1

## COMMITTEES AND COMMISSIONS

| | Actual | Budget | Actual Over (Under*) Budget |
|---|---|---|---|
| Standing committees: | | | |
| Grievance | 163.54 | 250.00 | 86.46* |
| Student Loan | 57.95 | 100.00 | 42.05* |
| Commissions: | | | |
| Constitution and Bylaws | 286.20 | 300.00 | 13.80* |
| Inter-Professional Relations | 401.90 | 300.00 | 101.90 |
| Legislation | 1,011.54 | 500.00 | 511.54 |
| Public Health | 562.20 | 500.00 | 62.20 |
| Public Information | 289.33 | 500.00 | 210.67* |
| Special Activities | 625.39 | 500.00 | 125.39 |
| Voluntary Health Agencies | 284.55 | 500.00 | 215.45* |
| Medical Economics and Insurance | 561.50 | 500.00 | 61.50 |
| Medical Education and Licensure | 843.29 | 500.00 | 343.29 |
| Planning | | 500.00 | 500.00* |
| Governmental Medical Services | 512.83 | 500.00 | 12.83 |
| Aging | 373.43 | 500.00 | 126.57* |
| Education | 5,504.41 | 15,000.00 | 9,495.59* |
| Contingencies | 1,116.44 | 5,000.00 | 3,883.56* |
| | 12,594.50 | 25,950.00 | 13,355.50* |

## OFFICERS AND COUNCIL

Schedule C-2

| | Actual | Budget | Actual Over (Under*) Budget |
|---|---|---|---|
| President | 411.96 | 1,500.00 | 1,088.04* |
| President-elect | 602.17 | 500.00 | 102.17 |
| Council chairman | 167.07 | 300.00 | 132.93* |
| AMA meetings | 18,871.51 | 15,000.00 | 3,871.51 |
| Treasurer—Auditing | 1,400.00 | 1,500.00 | 100.00* |
| Council meetings | 3,475.70 | 3,000.00 | 475.70 |
| Executive Committee meetings | 355.53 | 1,200.00 | 844.42* |
| | 25,283.99 | 23,000.00 | 2,283.99 |

## HEADQUARTERS OFFICE

Schedule C-3

| | Actual | Budget | Actual Over (Under*) Budget |
|---|---|---|---|
| Salaries | 69,739.94 | 90,000.00 | 20,260.06* |
| Supplies | 4,411.58 | 2,000.00 | 2,411.58 |
| Telephone and telegraph | 6,535.34 | 6,000.00 | 535.34 |
| Postage | 3,901.30 | 5,000.00 | 1,098.70* |
| Printing and statianery | 1,759.09 | 3,000.00 | 1,240.91* |
| Travel and entertainment | 7,855.86 | 9,000.00 | 1,144.14* |
| Building operations and utilities | 7,566.14 | 6,500.00 | 1,066.14 |
| Meetings—supplies and refreshments | 855.50 | | 855.50 |
| Insurance: | | | |
| Hospitalizatian | 3,848.47 | 1,500.00 | 2,348.47 |
| Other | 2,446.15 | 3,000.00 | 553.85* |
| Extra help | 699.53 | | 699.53 |
| Payroll taxes | 1,814.54 | 2,250.00 | 435.46* |
| Maintenance of office machines | 825.77 | 1,000.00 | 174.23* |
| Depreciation | 6,904.98 | | 6,904.98 |
| Unallocated | 457.13 | 500.00 | 42.87* |
| | 119,621.32 | 129,750.00 | 10,128.68* |

## STATEMENT OF INCOME AND EXPENSES ANNUAL MEETING

For the Year Ended September 30, 1965

Schedule C-4

| | | |
|---|---|---|
| Income from exhibitors | | 24,046.35 |
| Expenses: | | |
| Convention planning | 461.05 | |
| Entertainment—local committee | 412.27 | |
| Speakers travel and expenses | 1,635.24 | |
| Headquarters personnel | 403.41 | |
| Rent—convention hall | 1,750.00 | |
| Technical exhibits | 681.78 | |
| Women physicians | 153.68 | |
| Scientific exhibits | 525.50 | |
| Handbook and printing | 2,179.05 | |
| Badges | 384.32 | |
| Meeting—House of Delegates | 577.18 | |
| Banquet and party | 11,632.55 | |
| Watchmen | 420.35 | |
| Telephone services | 400.02 | |
| President's luncheon and reception | 3,190.79 | |
| Past-president's luncheon | 23.76 | |
| 50-year club | 125.14 | |
| Photography | 270.00 | |
| Miscellaneous | 793.31 | 26,019.40 |
| Excess of expenses aver income | | 1,973.05 |

## STATEMENT OF REVENUES AND EXPENDITURES

For the Year Ended September 30, 1965

Exhibit D

## THE JOURNAL

| | Actual | Budget | Actual Over (Under*) Budget |
|---|---|---|---|
| Revenues: | | | |
| Subscriptions: | | | |
| Members | 32,068.00 | 28,800.00 | 3,268.00 |
| Nonmembers | 1,269.00 | 1,000.00 | 269.00 |
| Advertising | 29,894.32 | 30,000.00 | 105.68* |
| Other | 4,050.12 | 5,000.00 | 949.88* |
| Total revenues | 67,281.44 | 64,800.00 | 2,481.44 |

| | | | |
|---|---|---|---|
| Expenditures: | | | |
| Salaries | 11,862.85 | 13,000.00 | 1,137.15* |
| Office expense and postage | 361.22 | 600.00 | 238.78* |
| Printing | 37,013.13 | 40,000.00 | 2,986.87* |
| Engravings | 3,901.72 | 3,600.00 | 301.72 |
| Travel and meetings | 1,507.50 | 1,800.00 | 292.50* |
| Bulk mailing | 1,598.07 | 1,500.00 | 98.07 |
| Other publishing expense | 362.50 | 550.00 | 187.50* |
| Payroll taxes | 388.34 | 500.00 | 111.66* |
| Employee group insurance | 179.10 | 150.00 | 29.10 |
| Rent and electricity | 3,408.00 | 3,450.00 | 42.00* |
| Telephone and telegraph | 306.67 | 450.00 | 143.33* |
| Unallocated | 337.74 | 100.00 | 237.74 |
| Total expenditures | 61,226.84 | 65,700.00 | 4,473.16* |
| Excess of revenue over expenditures (expenditures over revenue) | 6,054.60 | 900.00* | 6,954.60 |

## STATEMENTS OF REVENUES AND EXPENDITURES

For the Year Ended September 30, 1965

Exhibit E

### MEDICAL DEFENSE FUND

| | | |
|---|---|---|
| Revenues: | | |
| Transfer of applicable portion of dues | | 4,815.25 |
| Dues received direct—senior members | 63.75 | |
| Interest earned—U. S. Government bonds | 964.46 | |
| Total revenues | | 5,843.46 |
| Expenditures: | | |
| Attorney fees | 2,790.00 | |
| Stationery and printing | 25.65 | |
| Total expenditures | | 2,815.65 |
| Excess of revenues over expenditures | | 3,027.81 |

Exhibit F

### STUDENT LOAN FUND

| | | |
|---|---|---|
| Cash balance, September 30, 1964 | | 12,925.46 |
| Revenues: | | |
| Collection of student loans | 8,016.70 | |
| Interest earned | 714.34 | |
| Donation received | 1,000.00 | 9,731.04 |
| | | 22,656.50 |
| Expenditures: | | |
| Loans to general fund | 18,564.69 | |
| Investment in savings and loan shares | 2,947.03 | 21,511.72 |
| Cash balance, September 30, 1965 | | 1,144.78 |

# Association News

## EXECUTIVE COMMITTEE

October 11, 1965

Present: Ralph V. Everly, M.D., chairman; G. O. Larson, M.D., Joseph M. Black, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.

Frank B. Ramsey, M.D., editor of *The Journal*, Ralph Hamill, attorney and James A. Waggener, executive secretary.

### Headquarters Office

The secretary, in accordance with instructions of the committee, presented the proposed recording equipment to be used for recording AMA meetings and other meetings of such type and reported that he had borrowed this equipment for trying out during the state convention. By consent it was agreed that any action on the purchase of this equipment would be deferred until the Thursday meeting of the Executive Committee.

### Building Matters

The chairman of the Building Committee discussed building matters, particularly the drive to the exit on Fortieth Street and the secretary was instructed to lodge a complaint with Wil-Ten Corporation on the narrowness of this exit.

The secretary reported on the mechanical problems he had been having with the air conditioning and that it was going to be necessary to do an extensive overhaul job on this equipment, which would be an expensive matter.

### Treasurer's Office

The treasurer's report was approved on motion of Drs. Larson and Rifner.

### Annual Convention, October 12-14, 1965, Indianapolis

Arrangements for the convention and the Gaslight party were reviewed by the secretary. Upon motion of Dr. Neumann, taken by consent, the Executive Committee commended the Commission on Convention Arrangements and the executive secretary for these arrangements.

The President's luncheon was discussed and upon motion of Drs. Rifner and Neumann, the president is to be given tickets for distribution to the officers of the state of Indiana.

A brief report was given on the arrangements for the special members meeting on Medicare on Wednesday afternoon and on the sale of exhibit space.

### Legislation

*National*: Dr. Black reported on the meeting with the Liaison Committee of Indiana University on the DeBakey bill.

The secretary read a letter from Wilbur J. Cohen, Under Secretary of Health, Education and Welfare, in reply to a letter from the association, and upon motion of Drs. Rifner and Larson, the secretary was instructed to file a position paper with the department.

A Blue Shield letter and a policy statement of the AAGP were reviewed, as well as a policy statement of the American College of Radiology concerning radiologists separating their services from hospital services.

The secretary reviewed, for the information of the committee, the Social Security coverage for physicians and a statement from Senator Bayh concerning repeal of Section 14(b) of the Taft-Hartley Act.

### Organization Matters

Minutes of the September 8, 1965 meeting of the State Board of Medical Registration and Examination were reviewed for the information of the committee.

Letter from Dr. Thomas O. Middleton of Bloomington, Indiana, regarding an informal conference which is being set up with the intention of developing a project for intensive investigation of human factors in automobile accidents was read. By consent, Dr. Middleton's plan for probing causes of accidents and suggesting authority to work with the School of Police Administration at Indiana University was approved.

A letter from Dr. Kenneth G. Kohlstaedt recommending Dr. John Layne, of Montana, for a position on the Council on Medical Service of the American Medical Association was read for the information of the committee.

Letter from the Continental Casualty Company was reviewed for the information of the committee.

The minutes of the Blue Cross-Blue Shield Labor Advisory Committee were reviewed for the information of the committee.

A letter from Robert C. Colvin, M.D., was read for the information of the committee, as was a letter from Edward A. Tyler, M.D.

A bulletin from the Ohio State Medical Association, pointing out that the Ohio Industrial Commissions' Bureau of Workmen's Compensation will start paying physician's usual and customary fees in that state in October was read for the information of the committee.

### New Business

Minutes of the July 18, 1965, Council meeting concerning the creation of a Commission on Rehabilitation were discussed and upon motion of Drs. Neumann and Rifner, this is to be placed as a responsibility of the Commission on Special Activities until such time as there is a demonstrated need for a separate commission.

Discussion was held about various matters of expenses of the association and the secretary was instructed to obtain information from other states as to what they do in relation to the expenses of their presidents.

### The Journal

Letter from Wallace Laboratories concerning reprints from *The Journal* was reviewed and referred to the Committee of Business Consultants for *The Journal* from the Council.

### Future Meetings

American Medical Association Clinical Convention, Philadelphia, November 27 to December 1, 1965. Plans for this meeting were discussed and the secretary's office will make the housing arrangements for the members of the committee.

There being no further business, the meeting was adjourned to meet again at the conclusion of the Council meeting, following the final session of the House of Delegates on Thursday, October 14, 1965, for the purpose of organization.

## EXECUTIVE COMMITTEE

October 14, 1965

The Executive Committee convened following the close of the Council meeting, with the following members present:

Ralph V. Everly, M.D.; G. O. Larson, M.D.; Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; E. T. Edwards, M.D.; Ottis N. Olvey, M.D., and Lester Hoyt, M.D.

James A. Waggener, executive secretary.

It was announced that the Council had re-elected Dr. Everly and Dr. Larson as members of the Executive Committee for 1965-66 and that Dr. Olvey and Dr. Hoyt were re-elected treasurer and assistant treasurer respectively.

Dr. Edwards was welcomed as a new member of the Executive Committee, having been elected chairman of the Council.

By secret ballot, Dr. Ralph V. Everly was elected chairman of the Executive Committee for the year 1965-1966.

Due to the lateness of the hour no additional business was transacted and the meeting was adjourned to meet upon the call of the chairman.

## EXECUTIVE COMMITTEE

October 27, 1965

Present for a special telephone conference Oct. 27 were: Ralph V. Everly, M.D., Lester Hoyt, M.D.; Eugene S. Rifner, M.D.; G. O. Larson, M.D.; Ottis N. Olvey, M.D., and James A. Waggener, executive secretary.

Absent from the conference were Kenneth O. Neumann, M.D. and E. T. Edwards, M.D.

A guest on the conference call was Dr. Jack Hall, Methodist Hospital, Indianapolis.

Dr. Everly opened the conference with the comment that he had been contacted by Dr. Jack Hall of the Methodist Hospital with the request that the Indiana State Medical Association write a letter of endorsement or approval for the establishment of a renal dialysis unit at the Methodist Hospital and called upon Dr. Hall to explain this request.

Dr. Hall stated that they had an opportunity to obtain a three-year federal grant of $15,000.00 to support the installation and operation of a renal dialysis center at Methodist Hospital and that the community would be required to take over the responsibility for the operation and maintenance of this center after the grant is discontinued.

Dr. Hall stated that they had letters of endorsement from the county medical society, the Central Labor Council, the Chamber of Commerce and other community groups including the United Fund, for the support of this center.

Dr. Hall pointed out that he envisioned that this center could be used for the treatment of patients from any part of the state and it also could be used as a teaching center for other physicians who might be interested in this operation.

Dr. Rifner asked Dr. Hall if the association gave such a letter of endorsement, would this preclude the University Hospital from establishing a similar unit, if such were desired, and also, what effect the establishment of a unit at Methodist Hospital might have on other communities such as Fort Wayne which, he understood, was considering installing such a unit in their community.

Dr. Hall stated that he did not feel that the establishment of a center at Methodist Hospital would detract from the installation of a similar unit at the University or in any other community in the state of Indiana.

At this point Dr. Hall left the line and the matter was discussed by the other members of the committee.

Upon motion of Drs. Olvey and Larson, it was voted that the association write a letter of approval to Methodist Hospital. Motion was put to vote and carried.

## EXECUTIVE COMMITTEE

November 1, 1965

Present for a special telephone conference Nov. 1 were: Kenneth O. Neumann, M.D.; Eugene S. Rifner, M.D.; E. T. Edwards, M.D.; Ottis N. Olvey, M.D.; Lester Hoyt, M.D.; Ralph V. Everly, M.D.; G. O. Larson, M.D., and James A. Waggener, executive secretary.

The secretary explained the reason for this telephone conference was that several matters had arisen which he felt needed immediate attention.

The first item was the payment of expenses for two science writers from Indianapolis papers to attend the seminar on medical writing to be held in Chicago on November 4 and 5. This was discussed and by agreement the majority were in

favor of paying the expenses of two science writers to this seminar. Two members of the committee dissented.

The secretary then explained that he had been contacted by Dr. Joseph Black, immediate past-president of the association, that he had received an invitation to attend a White House Conference on Health, to be held in Washington, D. C., November 3 and 4. Dr. Black requested an answer as to whether or not he should attend and, if so, would the association be responsible for his expenses.

Dr. Everly took the chair at this time and discussion was held concerning the purposes of the conference, the outline of the program and the probable results of such a conference.

Upon motion of Drs. Edwards and Olvey, the committee voted that the association be represented at this conference by either a member of the Executive Committee or Dr. Black, at association expense, and that the representative report to the Council at its next meeting. The motion was put to vote and was carried, with Dr. Neumann dissenting.

It was explained that according to the communication from the White House, the invitation was not transferable, which would necessitate the representative being Dr. Black, unless the invitation could be altered to be directed to someone else. It was then decided that Dr. Black should be invited to attend.

The secretary then read a proposed resolution as directed by the House of Delegates for presentation at the Philadelphia meeting of the American Medical Association and by consent the resolution was approved for forwarding to the American Medical Association.

Dr. Neumann then discussed the action of the committee at its telephone conference on Wednesday, October 27, in giving approval to Methodist Hospital to install a renal dialysis unit. He expressed the opinion that this was outside of the province of the state medical association.

# THE COUNCIL

October 11, 1965

The Council convened at 2:00 p.m., Eastern Standard Time, in Parlors B and C of the Columbia Club, Indianapolis, on October 11, 1965, with Dr. Eugene S. Rifner, the chairman, presiding. Roll call showed the following present:

**Councilors:**

First District—P. J. V. Corcoran, Evansville
Gilbert M. Wilhelmus, Evansville, alternate
Second District—E. T. Edwards, Vincennes
Third District—Donald M. Kerr, Bedford
Elmer L. Wallace, New Albany, alternate
Fourth District—Robert M. Reid, Columbus
Jack E. Shields, Brownstown, alternate (also AMA delegate)
Fifth District—V. Earle Wiseman, Greencastle
Sixth District—William R. Tindall, Shelbyville
Frank H. Green, Rushville, alternate (also AMA alternate delegate)
Seventh District—Charles A. Jones, Franklin, alternate
Eighth District—Donald R. Taylor, Muncie
Ninth District—Peter R. Petrich, Attica
C. G. Kern, Lebanon, alternate councilor-elect
Tenth District—Lowell H. Steen, Whiting
Lee Trachtenberg, Hammond, alternate
Eleventh District—Eugene S. Rifner, Van Buren
Lowell J. Hillis, Logansport, alternate
Twelfth District—Milton F. Popp, Fort Wayne
William R. Clark, Fort Wayne, alternate
Thirteenth District—Jene R. Bennett, South Bend

**Officers:**

Joseph M. Black, Seymour, president
Kenneth O. Neumann, Lafayette, president-elect
Ottis N. Olvey, Indianapolis, treasurer
Lester H. Hoyt, Indianapolis, assistant treasurer

**Journal:**

Frank B. Ramsey, Indianapolis, editor

**Executive Committee:**

Ralph V. Everly, Indianapolis, chairman
G. O. Larson, La Porte

**Guests:**

Guy A. Owsley, Hartford City, AMA delegate
Harold C. Ochsner, Indianapolis, AMA delegate
E. S. Jones, Hammond, AMA delegate
F. L. Land, Fort Wayne, AMA delegate
Robert M. Brown, AMA alternate delegate
Glenn W. Irwin, Jr., Indianapolis, dean, I. U. School of Medicine
A. C. Offutt, Indianapolis, State Health Commissioner

**Staff:**

Ralph Hamill, attorney
Kenneth W. Bush, administrative assistant
James A. Waggener, executive secretary

**On motion of Dr. Neumann, taken by consent, the word "approved" in item 5, line 3, under New Business, minutes of Council meeting held July 18, 1965, was changed to read "received." With this correction, on motion of Drs. Steen and Popp, the minutes of the July 18, 1965, meeting were approved as printed in the September, 1965, Journal.**

## Reports of Councilors

DR. STEEN, Tenth District, announced that the Tenth District Society would meet at Phil Smidt's on November 10.

DR. POPP, Twelfth District, announced that the next meeting of the Twelfth District would be held at Bluffton on May 18, 1966.

DR. BENNETT, Thirteenth District, reported that Dr. Otis Bowen, Bremen, had been elected district councilor at the district society meeting on September 29, 1965, for the three-year term ending October, 1968.

## Unfinished Business

1. *Transfer of fees for radiology and pathology services from Blue Cross to Blue Shield.* In the absence of Dr. Lowell Thomas, chairman of the Council Ad Hoc Committee with the Indiana Hospital Association, Dr. Rifner gave a progress report to date on this matter.

At the April 26, 1964, Council meeting, the Council instructed the legal counsel to study the report presented by the ad hoc committee at that time and to report to the Council the estimated expense for litigating this matter, if this becomes necessary, and also to make an effort to estimate the expense involved in the transfer of these services.

At the July 19, 1964, Council meeting, following a full report by Dr. Thomas and review of the actions taken by the AMA, letters from the attorneys setting forth legal opinions on this question, letters from the Indiana Association of Pathology and the Indiana Roentgen Society, and discussion by the legal counsel of the cost of litigation in this matter, the Council approved employment of legal counsel to litigate this question, if it could not be resolved in any other way.

At the October 12, 1964, Council meeting, information regarding the Indiana Medical Practice Law was presented to the Council which led to the Council's engaging Judge Hamill to investigate certain aspects of the law as they relate to hospitals contracting with Blue Cross to furnish professional services (x-ray and pathology) as hospital services. The ad hoc's recommendations for future action were to be held in abeyance until after Judge Hamill's report to the Council.

Judge Hamill reported that the brief was ready to be presented and he and Mr. Hollowell were awaiting instructions of the Council as to how to proceed.

At the April 4, 1965, Council meeting, the legal counsel for the association was authorized to go ahead with this matter in any manner that they saw fit.

On July 18, 1965, the Council voted to request the ad hoc committee to meet with the association attorneys and the opposing attorneys in order to bring this matter to a conclusion within a certain period of time, preferably by the time of the state convention, October 11-14.

The chairman then read the following brief report which was received from Dr. Thomas just prior to the October 11, 1965, Council meeting:

"We have had no meetings since our last report to the Council and have nothing new to report other than the new Medicare law which gives our x-ray and laboratory men exactly what they have been wanting so far as these particular (over 65) patients are concerned. This may be a means for our establishing such handling of billing by x-ray and lab men for *all* their services, we hope.

"Prior scheduling does not permit me to attend at the hour of your meeting."

Judge Hamill reported briefly on the Wabash County case, expressing the hope that this matter would be settled satisfactorily.

2. *Trust Committee of Indiana Medical Education Foundation.* **On motion of Dr. Steen, duly seconded, the Council voted to postpone the election of two members to the Medical Education Foundation Trust Committee until the next meeting of the Council.** These members will serve for the three-year term ending October 31, 1968.

## Reports of Officers

DR. JOSEPH M. BLACK, president:

Mr. Chairman, members of the Council, this is my swan song. It has indeed been a pleasure to represent you this year as your president, and I have enjoyed it. I want to thank each councilor and alternate councilor for the cooperation they have given me in the past. I also want to thank the Dean of the Medical School and Secretary of the Board of Health for their cooperation and help, the AMA delegates, the executive staff and the various secretaries, and the office force for their cooperation during my term of office.

I have very little to say, as I know you have a full agenda, but I would like to remark that the liaison committee has met with the University. It was a very fruitful meeting. I think this is due to the Dean and his interest in the medical association in their endeavors to cooperate with the physicians of Indiana. I feel this program should be pushed. I realize sometimes we frown upon some of their programs, but I think they should have our confidence.

I am very hopeful that we will have an efficient operation of our House of Delegates. There are many controversial issues coming up, but I do hope we will limit our debate to the pertinent points and be alert at all times to conduct our business as professional people. I have relieved the councilors of any specific responsibilities during the convention except your own meetings.

I have appointed reference committees outside the Council with the hope that members of the Council will make it a point to appear before the reference committees and speak concerning the subjects with which they should be familiar. I have one question I would like your advice on. The question is, should I limit the time of debate in the House? As you know *Robert's Rules of Order* provide for a person speaking on the same subject not more than twice and the debate can be limited to three or five minutes. I would like your advice.

DR. KENNETH O. NEUMANN, president-elect: Mr. Chairman, members of the Council: I have nothing to add at this time. I would hope that I will have the same fine cooperation during this coming year as Dr. Black has had.

DR. OTTIS N. OLVEY, treasurer: Mr. Chairman, members of the Council, AMA delegates, guests: The audit for the 1965 fiscal year has not been completed as we had hoped, for distribution at this meeting. Preliminary estimates, however, seem to indicate that for the first time in many years we have stopped our deficit spending. Income is approximately $14,000 more than we had anticipated when the budget was prepared, and expenditures have been reduced by about $20,000 over what was anticipated. We had figured a profit in the budget of a little over $4,000 but estimates now look as if it might run higher than that.

Dr. Olvey reported that the building debt had been reduced to $36,000.00 and that there was a possibility of soon starting to slowly rebuild the reserve funds of the association.

**On motion of Drs. Petrich and Wiseman, the report of the treasurer was approved.**

DR. FRANK B. RAMSEY, editor of *The Journal*: We are in a little better shape than we were last year. As has been reported by the treasurer, we had a planned deficit of $900 for this year, but as of the moment, we have a surplus of $5,500.00. Our advertising income is up a little, our printing costs are down, and it looks as if we are on our way to recovering some of our previous losses.

REPORT OF AMA DELEGATES: DR. GUY A. OWSLEY announced that all councilors had received a copy of the amended report of the special meeting of the AMA House of Delegates and that the actions taken at that meeting would be reviewed before the Indiana House of Delegates, at the conclusion of its meeting Monday evening, Oct. 11, in a panel discussion by the AMA delegates and officers of the association. Therefore, **on motion of Drs. Taylor and Petrich, the report of the AMA delegates was postponed until evening.**

The Council discussed the comments made by the Indiana delegation before the special meeting of the AMA House of Delegates. The chairman of the Council explained that this was the consensus of the delegation, and the statement was written as a composite of the thinking of the Indiana delegates and the Executive Committee. The Council was reminded of their meeting with the Executive Committee and the delegates and that they were authorized to speak in behalf of the Indiana State

Medical Association. The chairman of the Council pointed out that Indiana was not alone in expressing these feelings.

## Matters Referred to Council by Executive Committee

DR. RALPH V. EVERLY, chairman of the Executive Committee, presented the following matters:

1. *Better Business Bureau membership for 1966.* **On motion of Drs. Bennett and Popp, the Council authorized the payment of a $175.00 membership in the Better Business Bureau for 1966.**

2. *Resolution on Remuneration under PL 89-97.* At the request of the Council, the following resolution was read, and **on motion of Drs. Steen and Clark, it was referred to the House of Delegates:**

WHEREAS, Public Law 89-97—89th Congress, known as Medicare, is scheduled to become effective July 1, 1966, and,

WHEREAS, it is reported one of the provisions included in the law is that "if physicians accept an assignment of payment—they must accept a fee set by the government as full payment; regardless of their usual fee, or any agreement made between the physician and his patient regarding the fee," and,

WHEREAS, "if the physician bills the patient directly, he is entitled to charge and collect his usual fee or a fee agreed to by his patient, the patient then submits a paid receipt to the government for reimbursement under the terms of the law."

NOW THEREFORE BE IT RESOLVED, that the Council of the Indiana State Medical Association check these facts—and so advise the members of this association of the provisions of this law in this regard.

3. *St. Paul Mercury Insurance Company matter.* In 1944, the House of Delegates approved the St. Paul Mercury Insurance Company as the sole official carrier of malpractice insurance for physicians in Indiana. The Executive Committee recommended that this matter be restudied to determine whether or not the House of Delegates wishes to continue this approval or to discontinue the agreement with St. Paul Mercury. **Following discussion by many, on motion of Drs. Popp and Petrich, this matter was referred to the House of Delegates for action.**

4. *Resolution proposed by the Louisiana State Medical Society on Certification of Welfare Patients* was submitted to the Council for consideration as to whether or not it should be referred to the House of Delegates for its consideration. **Following discussion by many, the motion of Drs. Petrich and Popp that the resolution be referred to the House of Delegates was withdrawn.**

## Economic and Organization Matters

1. *District nominations for Blue Shield Board of Directors for three-year terms ending March, 1968.* Dr. Rifner reported that at the Eleventh District meeting on September 15, Dr. John A. Bowers, Kokomo, (ENT), was renominated a member of the Blue Shield Board of Directors for the three-year term ending March, 1968. Nominations previously confirmed to the Council are:

District 2—C. Philip Fox, Washington, General Surgeon

District 3—John M. Paris, New Albany, General Practice

District 6—Frank H. Green, Rushville, General Practice and Surgery

2. *Election of councilor, Eleventh District.* Dr. Rifner announced that Dr. Lowell J. Hillis, Logansport, was elected councilor of the Eleventh District at the September 15 district meeting.

3. *Election of Journal editors.* **On motion of Dr. Popp, seconded by several, Dr. Frank B. Ramsey, Indianapolis, was re-elected editor for 1966.**

At the April 4, 1965 meeting of the Council, Drs. Alvin J. Haley, Fort Wayne (general practice), Richard D. Hawkins, Bedford (pediatrics), and Franklin J. Premuda, Hammond (pediatrics), were nominated for membership on the Editorial Board, **and on motion of Drs. Steen and Petrich the nominations were closed.**

**On motion of Drs. Steen and Popp, the Council voted to reconsider the actions taken on April 4 and to reopen the nominations.**

**Dr. Steen then nominated Dr. Wei-Ping Loh, Gary (clinical pathology).**

**On motion of Dr. Popp, seconded by several, the nominations were closed.**

**On ballot vote, Drs. Haley and Loh were elected to membership on the Editorial Board for the three-year term ending December 31, 1968.**

## New Business

1. *Indiana's Medical Educational Facilities.* Following discussion by several, including the dean of the Indiana University School of Medicine, **Dr. Bennett's motion that the Council introduce the following resolution to the House of Delegates, was seconded by many, put to vote, and carried:**

## Expansion of Indiana's Medical Educational Facilities

WHEREAS, Indiana's growing population and expanding economy have created an increasing demand for health care services, and,

WHEREAS, despite the splendid efforts of faculty and administration, the Indiana University School of Medicine, one of the largest of such schools in America, cannot train the number of physicians who will be needed in our state in future years or who will constitute our state's contribution to the national pool of physicians,

NOW THEREFORE BE IT RESOLVED, that the Indiana State Medical Association urge the proper authorities of the state of Indiana to take appropriate steps as soon as possible to bring about the orderly expansion of opportunities for medical education through the establishment of additional geographically distributed medical schools.

2. *Resolutions to be introduced* in the House of Delegates were not discussed, as each councilor had copies in his agenda.

3. *The appeal to the Council of a former member of one of the component county medical societies*, as provided for in the Constitution and Bylaws, was discussed by several, **and on motion of Drs. Petrich and Corcoran the Council voted that the chair should appoint a committee to establish the procedure to be followed in an attempt at conciliation. On motion of Drs. Steen and Petrich, put to vote and carried, receipt of the complaint and the notice of appeal is to be acknowledged by the Council.**

## Reports of Guests

DR. GLENN W. IRWIN, Jr., dean, Indiana University School of Medicine: My speech has been given in part earlier today, however, I would like to report a few things. We have admitted the same number of freshman medical students this year as last, namely, 215: 194 are at the Indianapolis campus and 21 are at Bloomington in the combined degree program. Last year's class was an unusual one for its academic performance, since we lost only three students because of academic reasons. The Admissions Committee predicted that this would be a good class and if you recall, last year Dr. Nurnberger and Dr. Ritchey pointed out that in the 1,050 applicants for that class, there were perhaps 20-25 that might have been acceptable, but who were rejected. This year that was not true.

There were about 1,150 applicants this year and I do not believe any qualified Indiana applicants were rejected. There has been an increase in the number of applicants during the past several years. Most of these come from out of state, although the in-state applicants list is also increased. If a second medical school was in operation next year, I doubt if we could select 300 good students from the application list unless we should take a large percentage of out-of-state students.

It is granted that by the time a second medical school is in operation, the number of qualified Indiana applicants may be increased significantly. I think our students have a new enthusiasm this year. They realize the Alumni Association is behind them. As you know, last year was decreed the John Van Nuys Memorial year and considering this is the first year, a substantial amount of money was raised. This has been directed to provide student scholarships and to support continuing medical education, which to me must take on a new emphasis as far as our school is concerned.

We have increased the number of faculty members somewhat and now have approximately 205 full-time and about 405 part-time persons. The part-time faculty has been increased trying to get good teachers as well as research oriented people. A proper balance between the two must constantly be maintained. Recruiting additional faculty is difficult these days. There are 14 new medical schools recruiting new faculty members and the competition with these, private practice and with other schools like ours, is considerable. So you do not add 30 new faculty members in a year, at least capable, outstanding persons. Our curriculum committee is continuing to be very active and I am sure there will be major changes in programs for medical students.

Recently, the Liaison Committee of the Indiana State Medical Association met with several of the clinical chairmen of the School of Medicine. There are plans for extending the preceptorship program, which has been very successful even though conducted on a very small scale. Those students who have shown a good performance should have an opportunity to take an increased number of a variety of preceptorships. In the future, students may be taking well-established programs in various hospitals throughout the state, in certain clinics and with individual physicians. This contact with physicians in practice in the state should help attract students to stay permanently in Indiana. The student curriculum is important and until there is a major change, I hope that members of this association will present the story of the practice of medicine in Indiana to students at the school at regular intervals.

Some students tend to emulate their full-time instructors, and for this reason there is need to constantly self-examine our programs so that students do have proper contact with men who are primarily in the practice of medicine. When schedules for rounding on the clinical services are prepared, we try to be sure there are an adequate number of faculty members in Indianapolis in contact with students. With the development of a new curriculum, I would visualize faculty existing throughout the state.

Our school may have a difficult time during the next few years because many people consider that we entirely favor the Booz, Allen & Hamilton report which is not true. We are concerned that a second medical school will be established prematurely. Most everyone in this room will agree that there is a need for additional facilities and faculty at the Indiana University School of Medicine. There are a variety of projects to be done such as strengthening the postgraduate and continuing medical education areas in an attempt to keep our graduating medical students in Indiana. If a second state supported medical school is established within two years, the two schools would likely be in considerable financial competition which might put us back to the days of 1903 when we had several schools. I am hopeful we do not go through that era again.

I have appointed a committee of the faculty with representation of this association and others to study the federal regional center or program bill. Dr. John B. Hickam is chairman of this committee which believes a regional medical program could be used in Indiana to improve our postgraduate and continuing medical education efforts throughout the state. The AMA and other organizations were effective in altering the original bill in such a way that it should be very useful to Indiana if we are fortunate to obtain such a program.

I appreciate very much this opportunity to speak

to the Council of the Indiana State Medical Association.

*Committee to study DeBakey Bill.* Dr. Ochsner suggested that it would be well for the Council to consider appointing a committee to study the DeBakey Bill, and Dr. Irwin agreed. After further discussion, **on motion of Drs. Petrich and Corcoran, the Council voted that the president be authorized to appoint an ad hoc committee to work with the University in the study of the DeBakey Bill.**

DR. LESTER H. HOYT, member of the Professional Advisory Committee of Blue Cross, reported that at the Blue Cross Board meeting on September 27, Mr. Spring reported that the government had made a preliminary decision to use the Blues as carriers for the Medicare program in Indiana. Mr. Spring also reported that operating expenses were about the same as for the previous year. The average cost of cases rose from $276.00 to $291.00. The average length of stay rose from 8.4 to 8.57 days per case. A gain of 400 in membership was realized in the intervening period. Mr. Spring also related that the board is developing supplementary plans for the benefit of those who will be covered under the Medicare program.

## Matters from Committees and Commissions

1. *Student Loan Committee.* In the absence of Dr. Lester D. Bibler, chairman, the chairman of the Council called attention to the report of the Student Loan Committee which stated that "There is $20,810.00 on deposit with the Indiana National Bank to guarantee loans made to students under the new program. To date, under the arrangement with the Indiana National Bank, 51 loans, totaling $41,900.00, have been granted."

2. *Council Liaison Committee with Blue Shield.* The chairman of the Council reported that, at the meeting of the committee on October 10, it was reported that they had sold their dental program and also, they have requested to be considered as a carrier for this program under PL 89-97, as approved by the Council previously.

3. *Recommendations of the Commission on Constitution and Bylaws,* proposing five changes in the Bylaws and three changes in the Constitution, were called to the attention of the Council with the suggestion that the councilors study these changes carefully prior to action by the House of Delegates.

## Date for January Meeting

By consent, January 23, 1966, was selected for the next meeting of the Council.

There being no further business the Council adjourned, to meet again on Thursday, October 14, 1965, in the Little Auditorium, Athenaeum, immediately following adjournment of the House of Delegates.

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